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ABSTRACT

This is the third volume of a three-volume report on the Community Mental Health Center (CMHC) survey project undertaken to assess the impact of the Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grant program on the delivery of mental health services to older persons. This volume presents results from a 2-year follow-up survey (1985) of 224 CMHCs in 44 states to determine the on-going impact of the ADMS block grant on the provision of services. Chapter I examines issues in mental health services for the elderly. Chapter II describes the 1985 survey. Chapter III decribes site visits to CMHCs, Area Agencies on Aging (AAAs), and senior centers. Chapter IV presents findings from the 1985 survey and site visits that showed that: (1) the block grant funding method on CMHC programs and on geriatric mental health services continued to have a negative impact; (2) the aged remain an underserved population within CMHCs; (3) there is little cooperative interaction between CMHCs and AAAs and senior centers; (4) CMHC staff have inadequate training in geriatrics; and (5) service staff for the aged are inadequately trained in mental health. Also presented are recommendations for federal, state, and local reform. Chapter V describes five model programs which demonstrate successful efforts to deliver mental health services to the aged. Appendices include a summary of the 1983 survey and site visits; the 1985 survey instrument and interview protocols; and a tabulation giving levels of statistical significance. Thirty-five references are provided. (NB)

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ED275952

Mental Health Services for the Elderly

Report on a Survey of Community Mental Health Centers

Volume III

CG 019484

Action Committee
to Implement the Mental Health Recommendations
of the 1981 White House Conference on Aging

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MENTAL HEALTH SERVICES FOR THE ELDERLY

Report on a Survey of
Community Mental Health Centers

Volume III

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Action Committee
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Funding for this survey was provided by
The Retirement Research Foundation

1986

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EXECUTIVE SUMMARY

The Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging is an interdisciplinary group concerned with issues related to the quality, coordination, financing, and delivery of mental health services to older adults. The Action Committee is chaired by former U.S. Health, Education and Welfare Secretary Arthur S. Flemming, and is comprised of representatives from gerontology, nursing, psychiatry, psychology, social work, and law. Funding for the Action Committee's activities is provided by a grant from the Retirement Research Foundation.

Of particular concern to the Action Committee has been the problems associated with the delivery of outpatient mental health services to older persons and the implementation of the mental health recommendations of the 1981 White House Conference on Aging which addressed these problems. The Action Committee identified the following issues for priority attention and activity: (a) coordination of the delivery of local mental health and psychosocial services to older persons; (b) financing of mental health care, particularly the need to expand Medicare mental health benefits; (c) provision for adequately addressing the emotional needs of patients and families in Department of Health and Human Services hospice regulations; (d) assurance of quality treatment for and legal rights of mentally impaired nursing home patients; (e) development of accreditation standards and mental health training materials for the network of homecare providers; and (f) expansion of public and consumer education, particularly as it relates to ageism and the stereotyping of the aged. The Action Committee has initiated a series of projects in each of these priority areas.

The Community Mental Health Center Survey Project

In 1983, the Action Committee began a two-phase study of mental health services for the elderly. The study was designed to (a) assess the quality of mental health services being delivered by community mental health centers (CMHCs) to older adults, (b) determine the level of interaction between local mental health and aging services networks in the delivery of psychosocial services to the aged, and (c) evaluate the effect on such services of the change in federal funding practices due to the implementation of the Alcohol, Drug Abuse and Mental Health Services block grant method of funding.

The Community Mental Health Center Survey Project was conducted in two phases -- 1983 and 1985 -- each of which consisted of two stages: first, a mail survey of CMHCs (with special attention being given to obtaining information on the delivery of services to older adults); second, on-site interviews with CMHCs, area agencies on aging (AAAs), and AAA-related senior centers. The results of the 1983 phase of the project are reported in detail in volumes I and II of this report. The results of the second phase of the project, the 1985 CMHC survey, are reported in this volume (volume III).

The 1985 Study

In the first stage of the 1985 survey, the Action Committee, in conjunction with the National Council of Community Mental Health Centers, mailed a questionnaire

to 540 CMHCs. The questionnaire requested information on the impact of the block grant funding method, funding sources, geriatric programs, their client population, and professional and support staff. A total of 224 responses, representing a 41% response rate, were received from CMHCs in 44 states. The following is a summary of the mail survey findings:

- o 37% of CMHCs reported adverse effects due to the ADMS block grant system of federal funding, including:
  - Increases in client waiting periods for services
  - decreases in number of clinical staff
  - decreases in number of home visits
  - decreases in outreach efforts
  - decreases in consultation & education activities
  - decreases in evaluation activities
  - decreases in in-service training activities
- o CMHCs preferred the categorical method of federal mental health service funding to the current block grant system.
- o The elderly remain an underserved population, receiving only 6% of CMHC services.
- o 45% of CMHCs reported having no specific programs for the aged; many indicated they would like to establish such programs in the future.
- o Federal funding reductions impede the development of new aging programs.
- o Specialized programs are important in providing more types of services to older persons.
- o Few CMHCs reported having programs targeted toward minority elderly.
- o 41% of CMHCs reported they did not have any clinical staff members trained to deliver geriatric services.
- o CMHCs reported some improvement in contact with area agencies on aging and senior centers -- although only 18% have a formal agreement or contract for services.

The second stage of the project entailed on-site visits and interviews with 26 CMHCs and 24 area agencies on aging (AAAs) or their affiliated senior centers. The purpose of the interviews was to obtain more complete information on mental health services being delivered to older adults, the impact of the block grant on age-related services, and the nature and extent of interagency contact and cooperation between CMHCs, AAAs, and senior centers. Accordingly, two interviews were arranged for each site visit: one with CMHC personnel and one with AAA or senior center personnel. The following is a summary of the site visit findings which reinforces the findings of the mail survey:

Community Mental Health Centers

- CMHCs reported adverse effects on their activities due to block grant funding.
- CMHCs reported little increase in service delivery to the aged.
- The aged continue to be an underserved population.
- The block grant has had a negative impact on geriatric services.
- CMHCs prefer the categorical method of federal service funding to the block grant.
- CMHCs reported a decline in specialized aging programs.
- Few CMHC staff are trained to deliver geriatric services.
- Some CMHCs reported active programs for the aged.
- CMHCs reported a small increase in contact with area agencies on aging and senior centers.
- CMHCs want to improve services to the aged.

Area Agencies on Aging and Senior Centers

- AAAs and senior centers offer some mental health-related services and training programs.
- Few AAAs have plans to implement the mental health provision of the Older Americans Act.
- Aging services staff are often aware of the mental health service needs of their clients, but find obtaining such services difficult.
- AAAs and senior centers reported modest interaction with CMHCs.
- AAAs and senior centers want to collaborate with CMHCs in providing mental health services to the aged.

Findings and Recommendations

The most significant findings of the survey and site visits were (a) the negative impact of the block grant funding method on CMHC programs and geriatric mental health services, (b) the aged remain an underserved population within CMHCs, (c) there is little cooperative interaction between CMHCs and AAAs and senior centers, (d) CMHC staff have inadequate training in geriatrics, and (e) service staff for the aged are inadequately trained in mental health. In response to these findings and the mental health recommendations of the 1981 White House Conference on Aging, the Action Committee developed the following recommendations for federal, state, and local reform.

Recommended Federal Reforms

- Abolish the block grant method for the funding of mental health services.

- Reenact the Mental Health Systems Act of 1980, including a categorical system of funding for geriatric mental health services.

- Expand Medicare mental health coverage to a level that parallels medical benefits coverage.

- Amend the Older Americans Act to ensure coordination between state agencies on aging and state departments of mental health, and between area agencies on aging and community mental health centers in meeting the mental health and psychosocial needs of the elderly.

- The federal government should take administrative action, as necessary, to ensure that the existing interagency agreement between the National Institute of Mental Health and the Administration on Aging mandating mental health and aging service systems cooperation in the development and provision of psychosocial services to the elderly be implemented in an expeditious manner.

- The federal government should ensure that present and future geriatric mental health personnel needs are being met through clinical and research training programs supported by the Department of Health and Human Services, the Veterans Administration, and other Departments and agencies that serve the aged.

Recommended State Reforms

- States should allocate their service funds in a manner that ensures that the mental health needs of the aged are adequately addressed.

- State agencies on aging and state departments of mental health should take administrative action to ensure coordination and cooperation in their planning, development, resource allocation, and delivery of services, in order to develop and support and adequate continuum of psychosocial services to meet the diverse needs of older adults.

- State governments should enact legislation to establish programs specifically targeted to the mental health needs of the elderly in all state mental health systems.

- The directors of state agencies on aging, state departments of mental health, and directors of local area agencies on aging and community mental health centers should assume an active role in advocating for the development of comprehensive mental health services for older adults -- and take the issue before state legislatures, the Administration, and the Congress.

- States should restore and maintain full mental health funding under Medicaid at the 1981 level (with allowance for inflation) and change the Medicaid eligibility requirements so that all older persons below the poverty level with be eligible.

- State agencies on aging and state departments of mental health should initiate in-service training programs in mental health and aging at the state and local levels for mental health and aging service staff.

Recommended Local Reforms

- Local area agencies on aging and community mental health centers, and other mental health and aging service providers, should initiate formal intersystem interaction and coordination for the assessment, planning, development, and delivery of comprehensive mental health services to the aged.

- Community mental health centers, and other public and privately funded mental health systems, should establish outreach programs to ensure that adequate and suitable services are delivered on an equitable basis to the aged -- particularly to the minority elderly in the community.

- Local aging networks and mental health systems should initiate joint training sessions for mental health and aging service providers at the community level.

- Joint case management systems involving both aging and mental health networks should be developed at the community level.

- Interagency community action networks should be established at the local level to develop cooperative planning and program development for a continuum of mental health services for the aged.

Although this report focuses exclusively on mental health services for older adults, mental health care is an intergenerational and multidisorder concern. The lack of services for older persons mirrors the inadequacies of this nation's mental health system for other special need populations, such as children, adolescents, pregnant teenagers, as well as substance abusers, the developmentally disabled, and the chronic mentally disabled. Currently, those in need of mental health care must compete with one another for services and program funding, and this should not be the case. The Action Committee firmly believes that an adequate mental health system should be developed and supported to provide equal protection and appropriate services for all those in need of assistance.

As the purpose of this research project was to assess the impact of the block grants on the delivery of mental health services to the elderly in this country, the report focused primarily on deficiencies in the mental health system and current mental health policies. Nevertheless, the Action Committee would like to formally recognize the dedication and hard work of the

professional and support staff of community mental health centers, area agencies on aging, and senior centers and commend the substantial contributions of these organizations to the health and well-being of our nation's elderly.

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PREFACE

The Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging is an interdisciplinary group concerned with issues related to the quality, coordination, financing, and delivery of mental health services to older adults. The Action Committee is chaired by former U.S. Department of Health, Education and Welfare Secretary Arthur S. Flemming, and is comprised of representatives from gerontology, nursing, psychiatry, psychology, social work, and law. Funding for the Action Committee's activities is provided by a grant from the Retirement Research Foundation.

Of particular concern to the Action Committee has been the problems associated with the delivery of outpatient mental health services to older persons and the implementation of the mental health recommendations of the 1981 White House Conference on Aging which addressed these problems. The Action Committee identified the following issues for priority attention and activity:

- Coordination of the delivery of local mental health and psychosocial services to older persons;
- Financing of mental health care, in particular, the need to expand Medicare mental health benefits;
- Provision for adequately addressing the emotional needs of patients and families are inadequately addressed in the Department of Health and Human Services hospice regulations;
- Assurance of quality treatment for and legal rights of mentally impaired nursing home patients;
- Development of accreditation standards and mental health training materials for the network of homecare providers;
- Expansion of public and consumer education, particularly as it relates to ageism and the stereotyping of the aged.

The Action Committee has initiated a series of projects in each of these priority areas.

The Community Mental Health Center Survey Project

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funding practices due to the implementation of the Alcohol, Drug Abuse and Mental Health Services block grant method of funding.

The Community Mental Health Center Survey Project was conducted in two phases -- in 1983 and 1985 -- each of which consisted of two stages: first, a mail survey of community mental health centers (with special attention being given to obtaining information on the delivery of services to older adults); second, on-site interviews with CMHCs, area agencies on aging (AAAs), and AAA-related senior centers. The results of the 1983 phase of the project are reported in detail in volumes I and II of this report (Flemming, Buchanan, Santos, & Rickards, 1984) and summarized in Appendix A. The results of the second phase of the project, the 1985 CMHC survey, are reported in this volume.

Phase 1: The 1983 Study

Volumes I and II of the report (Flemming, et al, 1984) presented the Action Committee findings from the 1983 community mental health centers (CHMC) survey and site visits and included recommendations for federal, state, and local reforms for improving mental health services to the aged. The following are highlights of the 1983 findings:

- 48% of the CMHCs surveyed reported adverse effects due to the change to block grant funding.
- The elderly were an underserved group, receiving only 6% of CMHC services.
- Between 1981 and 1983, there had been a decrease in the number of specialized aging programs delivered through CMHCs.
- There has been a decrease in federal support for mental health care. Local and private support has been utilized to restore a portion of the loss of funding.
- There had been a reduction in the number of clinical service staff trained in geriatrics.
- CMHCs reported little contact with area agencies on aging.
- AAAs and CMHCs reported almost no coordinated service delivery and little routine interaction.

The 1983 findings are supported by other research.

Research supports the results of the 1983 Action Committee survey of community mental health centers. For example, in a survey of states designed to determine the availability of geriatric mental health programs, Myers (1983), reported that only 52% of the responding states provided mental health clinic or outpatient services specifically for older adults. In another survey of 36 CMHCs in 8 states, Estes and Wood (1984) found that reductions in federal mental health funding and the consolidation of programs into block grants were the major reasons for personnel reductions, service reductions, increased waiting lists, decreased quality of services, and a shift in priorities to chronic services; as well as for a shift towards services geared toward the private

sector, insurance coverage and clients fees, and away from lower-income clientele. Based on surveys and interviews with 71 CMHCs in 15 states, conducted during a study sponsored by the National Institute of Mental Health, Larsen and Jerrell (1984) reported that block grant legislation has had significant effect on mental health policy, with a shifting of emphasis toward the chronically mentally disabled, a deemphasis on programs to other special populations such as the aged, and continued underservice of the elderly in proportion to their numbers in the community. In a study of implementation of the ADMS block grant in 13 states, the U.S. General Accounting Office (GAO; 1984) reported that while the 25% decrease in federal funding between 1981 and 1983 was partially offset by previously allocated categorical funds and increased state support, future reductions were anticipated. The GAO found that states had made changes in the kinds of services that were provided, with an increased emphasis on care for the chronically mentally disabled and follow-up care for patients released from mental institutions, and on community-based residential care.

Mental Health Services Are Intergenerational and Multidisorder Issues

Although this report focuses exclusively on mental health services for older persons, mental health care is an intergenerational and multidisorder concern. The lack of services for older persons mirrors the inadequacies of this nation's mental health system for other special need populations, such as children, adolescents, and pregnant teenagers, as well as substance abusers, the developmentally disabled, and the chronic mentally disabled. Currently, those in need of mental health care must compete with one another for services and program funding, and this should not be the case. The Action Committee firmly believes that an adequate mental health system should be developed and supported to provide equal protection and appropriate services for all those in need of assistance.

Recognition is Due to Community Mental Health Center, Area Agency on Aging, and Senior Center Professionals and Staff

As the purpose of this research project was to assess the impact of the block grant on the delivery of mental health services to older persons in this country, the report focuses primarily on deficiencies in the mental health system and current mental health policies. Nevertheless, the Action Committee would like to formally recognize the dedication and hard work of the professional and support staff of community mental health centers, area agencies on aging, and senior centers and commend the substantial contributions of these organizations to the health and well-being of our nation's elderly.

Chapter I

ISSUES IN MENTAL HEALTH SERVICES FOR THE ELDERLY

Current estimates suggest that there are approximately 26 millions people aged 65 or older in the United States (about 12% of the population). While most older persons are psychologically healthy individuals, it is estimated that 10% to 28% of them have mental health problems that warrant professional attention (Gatz, Smyer, & Lawton, 1980; George, Blazer, Windfield-Laird, Leaf, & Fishback, in press). Supporting evidence for this estimate was provided by a national survey in which 19% of the respondents aged 65 and older indicated that they could use professional mental health assistance (Douvan, Kulka, & Veroff, 1978). It then can be estimated that currently there are between 2.6 and 7.3 million older Americans whose mental health disorders are serious enough to require professional care.

Scope of the Issues

The elderly are in need of mental health services.

What are the specific major mental health problems of the aged? Such a list, out of necessity, must both oversimplified and incomplete. Issues prominent in most analyses include the following:

- dysphoria and major depressive disorder are prevalent mental health disorders in the aged (Blilwise & McCall, 1985; Gurland & Toner, 1982);
- the elderly have a high suicide rate, with men over age 75 having the highest rate for all age groups (Mcintosh, 1983);
- alcohol abuse is a serious problem among some elderly (Kay & Bergman, 1980);
- polydrug use and misuse of prescription medications are also serious problems because the aged use more prescriptions and consume more over-the-counter drugs than any other age group (Eisdorfer & Cohen, 1978);
- many chronic mentally disabled persons are now living into old age, with some joining the ranks of the homeless or being "lost" in nursing homes (Frazier, Lebowitz, & Silver, 1986);
- phobias are a prevalent disorder among the aged (George, et al, in press);
- dementia and severe cognitive impairment are increasingly prevalent with advanced age (George, et al, in press).

In addition to receiving care related to these major disorders, the elderly could also benefit from mental health services oriented toward helping them cope with circumstances that may contribute to the development of disorders, such as stressful living situations, social isolation, bereavement, acute and chronic health conditions, and the burden of serving as a caregiver to a severely impaired family member.

Many of these mental health problems of the elderly could be successfully treated on an outpatient basis. However, it has been estimated that the majority of those over the age of 65 who are in need of mental health services will not receive them (Kramer, Taube, & Redick, 1973).

The elderly are underserved by the mental health system.

Historically, the elderly have been largely neglected by the publicly financed mental health system and by private mental health practitioners -- psychiatric nurse specialists, psychiatrists, psychologists, and social workers. Although National Institute of Mental Health data have shown that between 1971 and 1982 the percentage of elderly clients of community mental health centers increased nationally, from 3.4% to 6.0%, that is still well below the 12% that would be expected solely on the basis of the percentage of those over age 65 in the general population. The Action Committee's 1983 survey of community mental health centers supported the NIMH report on the lack of service delivery to the elderly. Figures on the percentage of older persons treated by private mental health practitioners suggest a similar pattern of neglect, as only 0.6% to 2.7% of their patients are elderly (Taube, Burns, & Kessler, 1984; VandenBos, Stapp, & Kilburg, 1981). Furthermore, mental health providers tend to cluster in localities where there is a high distribution of persons aged 20 to 64, and generally are unavailable to older people, a circumstance common to many since there are more counties across the country without any licensed providers (1,682) than there are with providers (1,393; Knesper, Wheeling, & Pagnucco, 1984).

The special mental health needs of racial and ethnic minority elderly also have been neglected by both public and private mental health systems. The community mental health movement of the 1960s and 1970s largely ignored these groups. Their service needs were never adequately assessed, and prevention and treatment programs were not designed to deal with their unique problems. Consequently, the minority aged continue to be significantly underrepresented in the utilization of mental health services (Kobata, Lockery, & Moriwaki, 1980).

There are major impediments that contribute to the underservice of the elderly.

It is not the intent of this report to define and fully explore the reasons for the underutilization of outpatient mental health services by older adults. Although the Action Committee's interest is on the federally-imposed impediments to adequate mental health care for older adults, the Committee recognizes that there are also significant state and county government factors that impede care for the elderly. In a review of changes in community mental health legislation made at the state level between 1978 and 1984, the Intergovernmental Health Policy Project (1984) reported that while services authorized and supported for special populations included the elderly, the priorities for these services are often directed to other target populations.

At the county level, the following factors serve to constrain the development of geriatric mental health services: (a) the distribution of authority between federal, state, and local governments and the issues of federal and state mandates; (b) funding and resource allocation, including limited county revenue generation and state mental health budgets that allocate 80% of available funds to institutional services; and (c) the continuing stigma against people with mental impairments and toware seeking mental health services (Jaskulski, 1983).

There are at least two major federally-imposed impediments to adequate mental health care for older adults. The first impediment lies in the Medicare provisions for outpatient mental health care which contain disincentives, for both patients and providers, for adequate mental health services. Medicare limits reimbursement for outpatient mental health care to $250 annually and requires that the patient pay 50% of the cost of this care (as opposed to only 20% of the cost for medical care). This imposes a significant financial burden for the older patient. In addition, direct Medicare reimbursement is limited to psychiatrists and to CMHCs associated with psychiatric or general hospitals. Free-standing CMHCs (which comprise 90% of the total number of centers) and nonphysician providers are prohibited from receiving direct reimbursement. This burdensome restriction not only serves to deny treatment to the aged, but also tends to encourage the increase in health care costs by reimbursing only the more expensive forms of treatment.

The second impediment to effective outpatient mental health care for older Americans is the lack of recognition at all levels of government that older adults require an array of integrated psychosocial services. A study by the U.S. General Accounting Office (1982) found that, while in many cases older adults require the same mental health services as younger persons (e.g., diagnostic services, treatment planning, crisis intervention, psychotherapy, and so forth), older patients also require specialized facilitative and support services, such as outreach, home visits, and transportation. The study identified the need for specialized interdisciplinary and interagency cooperation to assure adequate psychogeriatric assessment of physical, social, and mental health needs. It also cited the need to develop and implement comprehensive case management strategies to facilitate the older patient's interaction with other community-based organizations, and particularly with those services provided through the area agencies on aging.

The "mental health" service system (the CMHC) and the "aging" service system (the AAA) are, unfortunately, two uncoordinated governmental organizations at the present time with only the former being directed to the psychological needs of the elderly. The systems are largely dichotomized at the federal, state, and local levels.

The lack of an effective mechanism for the delivery of outpatient service to mentally impaired older adults also was cited as a continuing problem by the 1971 White House Conference on Aging, 1979 Conference on Mental Health and the Elderly (sponsored by the House Select Committee on Aging), 1978 President's Commission on Mental Health, Mini-Conference on the Mental Health of Older Americans (White House Conference on Aging, 1982); in a study by the U.S. General Accounting Office (1982) entitled "The Elderly Remain in Need of Mental Health Services"; and in surveys of community mental health centers conducted by the Action Committee (Flemming, et al, 1984) and by the National Council of Community Mental Health Centers (1984). Reports from all of these sources, and

from other studies too numerous to cite, have clearly documented the fact that the publicly financed mental health service systems in this nation have not met the mental health needs of America's older adults.

The 1981 White House Conference on Aging was concerned about the delivery of mental health services to older adults.

The continuing lack of effective delivery of mental health services to older adults was a major concern of the participants in 1981 White House Conference on Aging. Among the recommendations developed by the Conference were the following related to the improvement of services:

> Congress and the Administration should expand and develop adequate and appropriate mental health services for older adults (Recommendation #45).
>
> The limitation on Medicare reimbursement for outpatient and inpatient mental health services for the elderly should be set at the same level as for other medical services (Recommendation #132).
>
> Community Mental Health Centers should be required to allocate mental health professional and support staff and funds proportionate to the percentages of older adults in the catchment area (Recommendation #120-A).
>
> Mental health and health care services to the elderly should be provided with a sensitivity to and awareness of ethnic and cultural difference (Recommendation #161).
>
> There is a need to provide for a community-based continuum of care system to maintain and prolong an independent, best possible quality of life for our elderly population (Recommendation #163).
>
> All personnel involved in the delivery of services should be required to have gerontological and/or geriatric training (Recommendation #429).

The Action Committee was formed in order to encourage the adoption of these recommendations made by the 1981 White House Conference on Aging.

The 1984 amendment to the Older Americans Act could generate positive change.

In addition to conducting the survey described in this report, in 1984 the Action Committee joined with other mental health, aging, and professional associations in obtaining the passage of a mental health amendment to the 1984 reauthorization of the Older American Act. The amendment was designed to facilitate the coordination and cooperation between CMHCs and AAAs in the planning, development, resource allocation, and delivery of services to meet the mental health and psychosocial needs of older adults. The new provision amended Title III, Part B, Section 321 of the Act to permit states to offer:

> Services designed to enable mentally impaired older individuals to attain and maintain emotional well-being and independent living through a coordinated system of support services.

The Action Committee has continued to work with and encourage state governors and directors of departments of mental health and aging services to take the action necessary to implement this mental health provision. States increasingly have recognized the importance of cooperation between their service systems to meet the mental health needs of the elderly (Mental Health and Aging System Coordination Project, 1983), and several have developed cooperative working agreements between their departments of mental health and aging services for the delivery of coordinated psychosocial services to older adults. Within the past two years, several additional states, for the first time, have developed working agreements between their mental health and aging services departments at both the state and local levels. The strength of these agreements and their benefit to the aged population will depend upon the attention state and local officials give to monitoring the implementation of the agreements, establishing liaison contact in respective departments, and establishing a mechanism to resolve the inevitable conflicts between organizations.

Federal Initiatives

Marginal efforts have been made by the federal government to encourage the development of specialized psychosocial services for the elderly, and to support from the Administration on Aging has produced some model programs (Chapter V). However, during the site visits undertaken by the Action Committee in 1983 and 1985, it was found that CMHC-AAA interaction was, at best, infrequent and often limited to crisis management or an occasional program presentation. Because there has been no strong national mandate for a coordinated interagency service delivery system, the federal government appears to be responsible, in large part, for this state of affairs.

Federal initiatives for mental health care for the elderly prior to the Alcohol, Drug Abuse and Mental Health Services block grant.

The Community Mental Health Centers Act of 1963 is the primary federal initiative for the provision of community-based mental health care. When the program was launched, the CMHCs were envisioned by the Congress as the desired alternative to institutional care -- indeed, they were intended to be the centerpiece of the deinsititutionalization movement of the 1960s. Comprehensive community mental health centers were to provide all necessary services to assure a continuum of treatment that would allow patients to remain in, or return to, their homes and communities.

While CMHCs were initially organized as comprehensive care centers to provide services to individuals regardless of age, during the 1970s there emerged a trend toward the provision of services for special target populations. Consequently, in 1975 Congress mandated that newly-funded CMHCs should provide specialized aging services and this requirement was re-emphasized in 1978 amendments to the Community Mental Health Centers Act. While there has been some progress by CMHCs in expanding their aging programs, neither the 1975 nor the 1978 amendments provided adequate incentives for full implementation of the Congressional directives. Accordingly, in enacting the Mental Health Systems

Act of 1980, the Congress provided for special staffing and coordination grants for CMHCs with identified aging programs. This step was viewed with optimism by mental health and aging professionals since such financial incentives were intended to encourage CMHCs to implement categorical aging programs. Unfortunately, the Mental Health Systems Act of 1980 was never implemented. It was superceded by the Alcohol, Drug Abuse and Mental Health Services block grant method of federal funding.

The Alcohol, Drug Abuse and Mental Health Services block grant and the Gramm-Rudman-Hollings Balanced Budget Act have had significent impact on services.

Enacted in 1981 under the Omnibus Budget and Reconciliation Act, the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant method of federal services funding reflects the Reagan Administration's philosophy that mental health services should be planned and implemented by states rather than the federal government. Like the social services and other block grant programs, the law requires a substantial decrease in federal funding and provides relatively little direction to states on program priorities, allocation of funds, or accounting requirements. Although the mental health block grant language generally directs states to use funds for the "identification and assessment of mentally ill elderly individuals and the provision of appropriate service to such individuals," there are no mandates for specialized geriatric services. Further, there are no specific reporting requirements that hold state and local agencies accountable for the delivery of services to meet the stated directive. Although the Act does allow the Secretary of the Department of Health and Human Services to impose uniform program reporting requirements on states, both Secretary Schweiker and Secretary Heckler have opted to waive such requirements.

The ADM block grant method of funding fails to accomodate the specialized needs of the elderly. A major problem with the block grant approach with respect to the elderly and other special needs populations is the absence of a requirement for the uniform availability of services. It is left to the discretion of the state whether or not to target older clients for special services. Given this nondirective approach, adequate provision of needed services cannot be ensured. As the previously mentioned GAO study has indicated, a categorical approach to geriatric services is preferable, in that it can both mandate and provide for accountability related to specialized mental health needs of older adults. In fact, data collected by the Action Committee suggest that under the block grant system, established programs are being discontinued and that state priorities are emphasizing services for populations other than the aged.

Table 1 (on page 11) compares mental health appropriations before the block grant program was initiated (fiscal year 1981) to block grant levels in fiscal years 1983 through 1986.

TABLE 1

Federal Mental Health Appropriations Before Block Grants (1981) Through 1986 and Gramm-Rudman-Hollings Sequestration
(in millions)

FY 81	FY 83	FY 84	FY 85	FY 86	G-R-H*
$549	$439	$462	$490	$490	$469

*1986 funds available after Gramm-Rudman-Hollings sequestration.

Concurrent with the implementation of the block grant method of federal service funding in 1983, there was an immediate 25% decrease in federal expenditures for mental health, alcohol, and substance abuse services. Between 1981 and 1985 there was a $59 million decrease in funding, which further reduced support for programs that were already severely underfunded, which, in turn, was compounded by a 17.4% increase in the inflation rate. The significant decrease in federal funding under the ADMS block grant has placed considerable pressure on states to increase their mental health budgets. And while states have generally provided more mental health funding, the increases have barely kept pace with the rate of inflation.

The Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177), known as the Gramm-Rudman-Hollings balanced budget act, went into effect on March 1, 1986. The law reduces federal expenditures in 1986 by $12 billion, including reductions in the ADMS block grant, by sequestering 4.3% of FY 1986 appropriations. The debt ceiling legislation will mean further reductions in the federal budget through FY 1991 unless revenue increasing measures are enacted. It is anticipated that the effect of Gramm-Rudman-Hollings on programs for the aged will be substantial. Not only will the amount of federal funds available to CMHCs for services be reduced, but federal contributions to such programs as Medicare, Medicaid, the Older Americans Act, and the Community Support Program will also be decreased, making it unlikely that state resources will be able to fully compensate for the federal revenue loss. Gramm-Rudman-Hollings is having a divisive impact on services and research activity for the aged, pitting programs that should be fully funded against one another for scarce resources and jeopardizing programs that have demonstrated benefit.

At a time when the aged population is growing, the health resources that are available to them are shrinking. Accordingly, the Action Committee is concerned that without a federally mandated categorical program and stable federal government funding, the mentally impaired elderly will continue to be inadequately served by community mental health centers.

Rationale for the Survey

As the Action Committee considered 1981 White House Conference on Aging recommendations calling for increased CMHC services to older adults, it became evident that the block grant system provided no mechanism for measuring the scope of specific CMHC services to older adults or for assessing the general impact of the block grant program on such services. It also was obvious that because

federal program reporting requirements had been arbitrarily discontinued, there would be no national data available to determine whether changes in service provision had occured. Therefore, the Action Committee decided to undertake an independent survey of CMHCs to obtain current data on the impact of block grant funding on local programs.

The 1983 community mental health centers survey conducted by the Action Committee, was undertaken during the first year of the block grant program implementation. It revealed that the reduction of federal funding and lack of emphasis on services to the elderly by the states had had a significant negative effect on geriatric services. At the time of the 1983 survey, many of the CMHCs that were maintaining aging service programs were unsure about their ability to continue funding such programs in the future. The Action Committee, therefore, decided to conduct a two-year follow-up study to determine the on-going impact of the ADMS block grant program on services to the aged.

While there have been many independent studies that have measured the influence of Reagan Administration policies on a range of domestic programs, the Action Committee survey is the only one that deals with mental health services for older adults on a national basis. The survey findings are be useful to federal, state and local policymakers, as well as national, state, and grassroots organizations concerned with mental health and aging.

Chapter II

SURVEY OF COMMUNITY MENTAL HEALTH CENTERS

Summary of the 1985 Mail Survey Findings

- o 37% of CMHCs reported adverse effects due to the ADMS block grant system of federal funding, including:
  - increases in client waiting periods for services
  - decreases in number of clinical staff
  - decreases in number of home visits
  - decreases in outreach efforts
  - decreases in consultation & education activities
  - decreases in evaluation activities
  - decreases in in-service training activities
- o CMHCs preferred the categorical method of federal mental health service funding to the block grant system.
- o The elderly remain an underserved population, receiving only 6% of CMHC services.
- o 45% of CMHCs reported having no specific programs for the aged; many indicated they would like to establish such programs in the future.
- o Federal funding reductions impede the development of new aging programs.
- o Specialized programs are important in providing more types of service to older persons.
- o Few CMHCs reported having programs targeted toward minority elderly.
- o 41% of CMHCs reported they did not have any clinical staff members trained to deliver geriatric services.
- o CMHCs reported some improvement in contact with area agencies on aging and senior centers -- although only 18% have a formal agreement or contract for services.

Introduction to the Survey

The community mental health centers survey project was conducted in two stages. The first stage involved a mail survey of community mental health centers (CMHCs). Special attention was given to obtaining information on the delivery

of services to older adults. The results of the mail survey stage are presented in this chapter. The second stage consisted of on-site visits and interviews with personnel of 26 CMHCs and 24 area agencies on aging or their affiliated senior centers. The results of the site visits are presented in Chapter III.

Method

A survey instrument (Appendix B) containing seven parts was developed. Part one contained questions requesting information on the impact of the Alcohol, Drug Abuse and Mental Health Services block grant method of funding, through the use of a "negative effect" to "positive effect" scale; estimates of how the center had been affected on eleven factors (Increased, No Change, Decreased), and indications of preference for either the block grant or the categorical method of federal funding. Part two requested information on federal, state, local, private, and other funding sources for 1984 (the most recently completed budget year) and 1981 (pre-block grant year). Questions in part three asked for the definition of "aged" used by the center, whether the CMHC offered or previously had offered a specific program for the aged, which services (i.e., assessment, outpatient, outreach) were provided for older clients, whether a member of the staff was trained to deliver services to the elderly, and percentage of aged clients served. The fourth part requested information on the center's interaction with area agencies on aging and other organizations providing services to the elderly and the sites at which services were delivered by the center. The fifth part requested information on the number of clients by age receiving services, client visits by persons over age 65, and the sex and minority status of older clients. Part six requested information on full and part-time professional and support staff, including the percentage of racial or ethnic minority staff. The seventh part consisted of a single question, asking whether the center would agree to a more in-depth on-site interview at a later time.

The questionnaire was mailed to 540 community mental health centers selected from the membership list of the National Council of Community Mental Health Centers (NCCMHCs). It was not sent to NCCMHC members that were not involved in the delivery of services to older adults (e.g., child guidance clinics). Each questionnaire was accompanied by a cover letter signed by both the Executive Director of the NCCMHCs and the Chair of the Action Committee, that explained the nature of the project and requested center participation. Two follow-up mailings were sent 4 and 8 weeks after the initial mailing. After 12 weeks, those CMHCs that had not responded were telephoned and asked to complete and return the survey.

A total of 224 responses, representing a 41% response rate, were obtained. Of these, 204 questionnaires (38%) contained consistently usable information. Twenty respondents returned blank questionnaires or letters indicating that they could not or would not provide the information requested. Reasons given for not participating included that a center did not receive federal funding, the data could not be obtained, or the center did not offer services for older persons.

Data were analyzed by means of the SPSSX statistical program for social science information. Analysis of variance, t-tests, and chi-square tests of statistical significance were employed as appropriate. The levels of statistical significance are reported in Appendix E.

The Sample of Community Mental Health Centers

Survey responses were received from CMHCs in 44 states and the District of Columbia, with the largest number being from Ohio (16), Illinois (13), Indiana (13), Pennsylvania (13), and Texas (10). The number of CMHC responses, based on the Department of Health and Human Services 10-region geographic system, were as follows: Region I (New England), 18 (8.8%); Region II (New York and New Jersey), 13 (6.4%); Region III (Mid-Atlantic), 23 (11.3%); Region IV (South), 26 (12.7%); Region V (Great Lakes), 53 (26.0%); Region VI (Lower-Midwest), 25 (12.3%); Region VII (Central-Midwest), 15 (7.4%); Region VIII (Upper-Midwest), 9 (4.4%); Region IX (Southwest & Hawaii), 11 (5.45%); and Region X (Northwest & Alaska), 11 (5.4%). There were no significant differences on the rate of survey response between the regions.

Overview of Results

Thirty-seven percent of community mental health centers reported adverse effects due to block grant funding.

Respondents were asked "How has your CMHC been affected by the federal ADMS block grant program?" Answers were given on an 11-point scale ranging from -5 (negative impact) to +5 (positive impact). Of 174 valid responses, 64 (36.8%) rated a negative impact of the block grant, 63 (36.2%) rated no effect, and 47 (27%) rated a positive effect. The number of respondents rating a negative impact of block grant funding is statistically significant (Appendix E, *1). These results are inconsistent with the Reagan administration's claim that the block grant would have "little" or "no" adverse effect.

These findings are consistent with the results of the 1983 Action Committee survey, in which a high percentage (48%) reported adverse effects due to the block grant and the accompanying reductions in federal support.

Community mental health centers report an increase in client visits, but a decline in ability to deliver services.

CMHCs were asked to indicate whether specific aspects of their functioning had increased, stayed the same, or decreased due to the federal block grant method of funding. Forty-seven percent of CMHCs reported an increase in the number of client visits between 1981 and 1984. The average number of annual visits reported was 30,886 in 1981; 32,579 in 1983 (Flemming, et al, 1984); and 38,859 for the current study. Thse data indicate a significant increase in the total number of clients receiving services between 1981 and 1984, the period spanning the introduction and use of the block grant.

Concurrent with the increase in the number of clients requesting services, 39% of the CMHCs reported an increase in waiting time for services; 31%, increased staff turnover; 44%, no change in clinical staff levels, and 28%, a decrease in clinical staff. CMHCs also indicated curtailment in center activities. For example, 28% reported reductions in in-service training programs; 39%, in consultation and education activities; and 33%, in evaluation activities.

Several centers reported increases in service activity. Twenty-eight percent reported an increase in outreach services, and 26% indicated an increase

in the frequency of home visits. Although few centers reported outreach efforts or home visits, it is noteworthy that some CMHCs reported an increase in such beneficial activities for the aged.

The decreases reported in services are consistent with the findings of the 1983 Action Committee survey, in which 35% of the CMHCs reported reductions in staff support and clinical services and 22% in administrative programs. Reductions were also experienced in consultation and education, prevention activities, outreach efforts, and support services such as maintenance and housekeeping.

Community mental health centers prefer the categorical method of federal funding.

In response to the question "Given an equal amount of funding, which method of federal funding would you prefer?," 43% of the respondents indicted a preference for the categorical method that was used prior to block grant funding, 34% preferred the block grant method, and 23% did not indicate a preference. The number of respondents preferring the categorical method of funding was significantly larger than those choosing the block grant method (Appendix E, #2).

Respondents also were asked to briefly explain why they preferred the block grant or categorical funding methods. It is notable that those who preferred categorical funding frequently referred to the impact of block grant funding on their ability to meet client needs, while respondents preferring block grant funding were frequently concerned with its impact on their administrative processes.

The following comments are illustrative of the responses received from centers preferring the categorical method of federal funding.

> The states do not spend in an "even handed way" -- categorical insures that grants go where demonstrated need and expertise exists.
>
> The block grant funding is limited to the chronically mentally ill population. Because of this, programs for other target groups have consistently been cut back.
>
> Block grant has forced us to cut back on vulnerable populations -- children, elderly, Hispanic and placed more emphasis on long term clients already served by our Center. I'm not talking about a greater balance in our care. We had to take away already limited service from the above groups and add more long term patients as mandated by the state.
>
> The categorical method better insures services to all segments of the population.
>
> More services were offered with less restrictions on client eligibility. Allowed more responsiveness to the community and special population needs, specifically the elderly.

The following comments are illustrative of the responses received from centers preferring the block grant method of federal funding.

> The block grant system provides greater flexibility and more local control than does the categorical grant. It is a great benefit to not have to complete the 200+ page application for the funds.
>
> Less paperwork and "red tape". However, block grant funds being restricted for special populations takes away local board's ability to allocate funds based on locally identified needs and priorities.
>
> Provides state opportunity to address local priorities by supplementing state and local dollars with federal funds, but much more is needed.
>
> There is a need, however, to require States to guarantee a basic array of services to certain federally mandated populations.

<u>There has been a significant change in community mental health center funding sources</u>.

The questionnaire requested information on federal, state, and local government funding of CMHCs, and on other public and private sources of financial support. Responses from several CMHC directors indicated that often they did not know the original source of federal or state funds that their CMHC received since, under the block grant system, they are funded through state departments of mental health and not directly by the federal government.

Table 2, on page 18, presents the sources of CMHC funding as a percentage of total center budget for the fiscal years (FY) 1981, before the block grant, and (FY) 1984, after the block grant programs began.

It is important to note that although 1981 is used as a baseline for comparing budgets before and after block grants were initiated, the funding available in 1981 did not provide adequate support for mental health services. Services to the aged were inadequately funded in 1981, and are even more inadequately funded at this time.

As a percentage of the overall budget, state and local funding to CMHCs has remained constant, while federal funding from ADMS and other block grants has significantly decreased. Increases in the payments received from Medicaid and in insurance reimbursements, as well as increases in client fees, have allowed CMHCs to compensate partially for such decreases. However, those sources do not provide the additional funding need to expand services to the aged.

It is apparent that CMHCs are receiving funds from a variety of sources, and that they are engaging in creative fundraising in order to maintain center operations. However, the need to rely on multiple sources of funding is seen as an impediment to those who plan and advocate for mental health services for the aged. For example, CMHC directors cannot rely on receiving funds at the same level, or at all, from one year to the next, and, therefore, they are likely to be cautious about undertaking the development of innovative programs and

outreach services designed to meet the needs of the elderly. This dependence also makes it difficult for advocates of geriatric services to know where to focus their efforts in terms of local, state, or federal initiatives.

TABLE 2

Funding Received from All Sources by
Community Mental Health Centers
Before Block Grants (Fy 1981) and After (FY 1984)

Source of Funding	Percentage of Annual Budget FY 1981	FY 1984
Federal & State Government		
Alcohol, Drug Abuse and Mental Health Services block grant funds	18.6%	14.6%*
Other block grant funds	3.1%	1.7%*
Research/demonstration grants	0.8%	0.5%
Medicare reimbursements	1.3%	1.5%
Older Americans Act funds	0.1%	0.1%
Medicaid	6.2%	9.0%*
State mental health funds	35.0%	36.4%
State aging funds	0.2%	0.2%
Other federal or state funds	7.2%	4.7%*
Local Government	12.0%	12.0%
Other Sources		
United Way	0.9%	1.1%
Philanthropy	0.4%	0.6%
Insurance reimbursement (excluding Medicare/Medicaid)	5.3%	6.2%*
Client fees	5.3%	6.5%*
Miscellaneous	4.4%	5.8%*
GRAND TOTAL	100.0%	100.0%

*Significant change between FY 1981 and FY 1984; $p<.05$.

New sources of community mental health center funding do not support services to the aged.

When budget contributions are expressed in percentages, changes in federal mental health funding practices do not appear to be drastic. However, the true impact becomes clearer when the dollar amounts of actual funds received by CMHCs from each of the funding sources are examined. Table 3 presents the average

dollar amounts that CMHCs received in FY 1981 and FY 1984 from federal, state, and local governments, and from private and other sources of funding sources. Since the rate of inflation between 1981 and 1984 was significant, the 1981 amounts have been adjusted using a 17.4% figure derived from the Consumer Price Index. This was done in order to place the true impact of changes in better perspective.

TABLE 3

Average Funding Dollars Received from All Sources by Community Mental Health Center Funding Sources
(Amounts in thousands of dollars)

Source	Dollars Received FY 1981*	FY 1984
Federal & State Government		
Alcohol, Drug Abuse and Mental Health Services block grant	$ 474	$ 369**
Other federal block grants	81	39**
Research/demonstration grants	16	22
Medicare reimbursement	72	77
Older Americans Act funds	2	2
Medicaid	160	255**
State mental health funds	850	958**
State aging funds	5	4
Other federal or state funds	215	170
Local Government	275	315
Other Sources		
United Way	12	14**
Philanthropy	11	14
Insurance reimbursement (excluding Medicare/Medicaid)	185	204
Client fees	125	150**
Miscellaneous	127	164
GRAND TOTAL	$ 2683	$ 2842

*Increased by 17.4% to reflect the rate of inflation between 1981 and 1984; based on Consumer Price Index.

**Statistically significant change between 1981 and 1984, $p<.05$.

The significant decrease in ADMS and other block grant funding, reported by 63% of CMHCs, is consistent with the Reagan Administration's retreat from federal responsibility for health care in America. Although 73% of the states have increased their mental health budgets significantly and 71% of the centers have experienced a similar increase in Medicaid funding, CMHCs have not had a real-dollar increase in their budgets in four years. The increased funding from state and Medicaid sources is often used to maintain services for the chronic mentally disabled and for deinstitutionalized patients, and is not applied toward improved geriatric services. The shift toward providing services-for-fee (reported by 73% of CMHCs) and services that are reimbursed by insurance (reported by 67% of CMHCs) represents an attempt to cope with budget realities, but, again, this effort does not meet the needs of the older population, who are unlikely to be employed or have adequate health insurance benefits for mental health services.

CMHCs are not receiving financial support commensurate with their mission to provide a broad range of services to satisfy the diverse needs of the community. Their programs have not been funded adequately enough to allow them to grow sufficiently to meet the needs of expanding special populations such as the aged the homeless, and the chronic mentally disabled. Despite the significant progress that has been made in making community mental health services available to these underserved populations, the goal embodied in the Mental Health Systems Act of 1980 (P.L. 96-398) -- to provide access to adequate private and public mental health and support services for those in need -- has yet to be realized.

Overall, CMHCs reported a negative impact by the block grant on their operations. The decrease in federal funding has necessitated centers developing other sources of funding in order to maintain their services. This need for new funding sources has resulted in a move by CMHCs toward providing only those services that can be paid for by insurance reimbursements or client fees, and those that are mandated by states. Reliance on this method of funding, in effect, impedes efforts to provide services on an equitable basis across mental health classifications and age, racial, and ethnic groups.

The aged remain an underserved population.

Comparing the results of the 1983 Action Committee survey with those of the 1985 survey, it is notable that the aged continue to comprise only 6% of CMHC clients. The percentage has remained constant since the block grant was implemented, inspite of an increase in the total number of older persons. Table 4 presents comparative information on the ages of CMHC clients receiving services.

TABLE 4

Age of All Community Mental Health Center Clients Served: Average Per Center

Age	Number Served FY1981	FY1984
1-17	433	512
18-64	1746	1969
65+	158	145

There was no significant change in the number or percentage of aged clients served by CMHCs between 1981 and 1984; the aged continue to comprise only 6% of the CMHC caseload. The percentages of aged clients served ranged from 0 to 23% across CMHCs in 1981 and from 0 to 33% in 1984. This large variation in the percentage of elderly clients served indicates that some CMHCs have very active programs targeting services for older adults, while others have made little or no effort to serve the elderly in their catchment areas.

Specialized programs are important to the delivery of services to the elderly.

CMHCs were requested to indicate which of 17 services listed in the questionnaire they provided to the aged. Centers that reported having programs for the aged delivered a significantly greater number of services to the elderly (an average of 11.2 services) than did those without an aging program (an average of 9.1)(*3). Furthermore, there were differences in the types of services provided. Centers with an aging program were more likely to provide elderly assessments (*4) and screenings (*5), support groups for the aged (*6), family services (*7), psychopharmacological clinics (*8), and outreach services (*9) than those without geriatric programs. Only centers with aging programs reported offering such additional services as telephone reassurance, consultation and education for senior centers and nursing homes, liaisons to nursing homes and area agencies on aging, and retired senior volunteer programs. Many centers, whether or not they had an aging program, offered elderly clients crisis intervention and emergency services, inpatient and some outpatient services, and case management services. Few centers offered day or respite care, forensic, or transportation services.

Forty-one percent of CMHCs reported that they did not have any clinical staff members trained in geriatric service delivery. However, CMHCs with an aging program also were more likely to have staff specifically trained to deliver geriatric services than were those without an aging program. However, the number of CMHC staff with training in aging (average = 1.7) represents only 5% of the total number of professionals on staff. Training frequently consisted only of workshop attendance and in-service programs, rather than formal graduate-level education.

Federal funding reductions restrict the development of new aging programs for the aged.

The majority of centers (112 CMHCs or 55%) reported having geriatric services targeted to the elderly and 45% reported having no program. These proportions are consistent with those found in the 1983 Action Committee survey (based on 127 respondents), but are below the level of 64% (149 respondents) reported in 1981 (before the block grant). Thus, the results suggest that the percentage of CMHCs with aging programs has remained constant between 1983 and 1985 surveys. Data analysis revealed that CMHCs with current aging programs were most likely to be those that previously reported having programs. Thus, almost no new aging programs were begun, and few programs were discontinued. CMHCs that reduced or terminated geriatric service programs did so because of funding reductions or because they lost their aging specialists due to staff and budget reductions.

Fifty-three percent of the CMHCs that do not currently have a geriatric services program indicated that they would like to develop one, but were prevented from doing so by budget constraints and state-designated priorities

that focused on other groups. There were almost no instances of new aging services being developed by CMHCs. This lack of emphasis on developing geriatric service programs exists in spite of the growing number of elderly and an increased knowledge and understanding of their mental health needs.

The block grant programs were promoted by the Reagan Administration as a means of providing fewer constraints on the ability of states to develop innovative mental health programs. In practice, however, the block grants have maintained the status quo with regards to the elderly, with little evidence of new state programs being initiated to meet demonstrated mental health needs. Even though there have been a few isolated increases in funding for services to the aged, it is apparent that the overall reduction in federal support, along with the subsequent changes in funding patterns for CMHCs, has inhibited the development of targeted programs for older adults.

Aged members of minority groups are rarely targeted for mental health services.

Only 59 CMHCs (30%) indicated that their centers made efforts to meet the needs of racial, ethnic, or linguistic minority elderly in their communities. Ninety-one centers (45%) failed to respond to the question, 19 (11%) reported increased activities to attract minority clients, and 18 (11%) reported decreased efforts. The efforts to attract minority clients most frequently consisted of attempts to ensure that the proportion of services and staff of the CMHC devoted to minority needs matched the proportion of minority members in the community. Though some CMHCs described outreach efforts directed to specific minority groups, only a few reported specialized programs targeted especially toward aged minority members.

Incomplete information was received on the delivery of mental health services by race and ethnicity. It is apparent that virtually all centers provide services to some minority clients, but their percentage of the overall client caseload cannot be determined from the available data.

Community mental health centers report some improvement in interactions with area agencies on aging and other organizations.

Data from the 1983 CMHC survey indicated that there was "almost no coordinated service delivery and little routine interaction" between CMHCs and AAAs (Flemming, et al, 1984, p. 17). The results of the 1985 survey indicate some improvements in the relationship between segments of the mental health and aging services networks; 18% of survey respondents reported that they had a formal agreement or contract for services with an AAA. Apart from contractual agreements, 25% of the CMHCs reported cooperation with AAAs in joint staff training and cosponsorship of workshops and conferences. Many CMHCs (58%) indicated that staff occasionally attended AAA events and meetings. Some (45%) noted that mental health information was disseminated through AAAs, and others (56%) that AAAs occasionally referred clients to them. A few CMHCs (14%) were representated on AAA boards and some CMHC boards (7%) included AAA representation.

On average, each CMHC indicated 4 such points of interaction, suggesting that relationships with AAAs are generally not extensive or comprehensive. This impression is supported by the finding that only 14% of the CMHCs responding

indicated that they provided any services in an AAA. Contact with AAAs was usually for consultation and education, rather than for treatment services.

It is notable that having a liaison with an AAA did not relate to differences in the amount of funding CMHCs devoted to services for the aged.

CMHCs also were asked to indicate the types of service sites used to deliver one or more of their geriatric services. Centers reported that they delivered services at an average of five types of sites. These included: CMHC facilities (100%), AAAs (14%), adult day care centers (30%), community action programs (8%), residential facilities (44%), state mental hospitals (42%), nursing homes (63%), hospice programs (7%), senior centers (43%), churches and clubs (35%), clients' homes (64%), prisons (16%), and homeless shelters (12%). The kinds of services delivered at these sites frequently consisted of consultation and education and information and referral services. Less frequently the services included case management, assessment and screening, and crisis intervention. Outpatient treatment services were usually provided only at the CMHC.

In response to the request for a description of any activities that may have helped to foster community understanding and support for the CMHC, respondents provided the following list of outreach efforts: community education programs and workshops on mental health issues, television and radio presentations, participation in health fairs, writing a counselor column for the local newspaper, fund raising, speaking at block association and civic group meetings, sponsoring a state conference on aging, conducting projects for children and the aged, and participating in the "Building Ties" program (see Chapter V) and in the Retired Senior Volunteer Program.

Staffing patterns varied.

In response to questions on the level of staffing, CMHCs reported having the following average number of staff members: 43 full-time equivalent professionals (median = 32), 8 administrative (median = 5), 16 paraprofessionals (median = 5), 7 volunteers (median = 0), and 16 support and clerical staff members (median = 12). Sixty percent of professional staff members were women.

Few regional differences were found.

A number of survey responses were examined for differences by geographical region, but few such differences were found. There were no significant differences on the following questions: respondent ratings of the negative impact of the block grant system, CMHC preference for the categorical method of funding, proportion of CMHCs reporting current programs for the aged, percentage of elderly clients served by CMHCs, and number and percentage of staff trained to deliver services to the aged. These findings are also consistent with those of the 1983 Action Committee survey.

There were regional differences in the proportion of respondents that indicated an ongoing relationship with an area agency on aging (*10). The New England and Southern regions were more likely to have such relationships in place, while the Upper-Midwest and Southwest regions were less likely to be working with AAAs.

Among those respondents that did indicate a relationship with an AAA, there were differences by region in the number of ways in which cooperation developed.

Mid-Atlantic and Northwest regions reported fewer areas of cooperation with AAAs than did other regions (*11); respondents from the Upper-Midwest reported the greatest number (*12).

Comparison of Community Mental Health Centers Reporting Adverse and No Adverse Effects

Substantial differences were found between CMHCs that reported a negative impact of the ADMS block grant method of service funding and those that did not. As indicated above, 37% of the CMHCs reported adverse effects due to the block grant funding method. Centers that indicated a negative impact had a significantly greater reduction in the amount of federal funding they received between 1981 and 1984 than did those reporting "no effect" or a "positive" impact (*13).

Community mental health centers reported that the block grant had a negative impact on services and operations.

There were significant differences in the impact of the block grant on CMHC services and operations between those centers reporting adverse effects and those that did not. Specifically, CMHCs indicating adverse effects were more likely to report increases in client waiting periods for service (*14) and greater staff turnover (*15); and decreases in the number of clinical staff (*16), in-service training programs (*17), outreach services (*18), home visits (*19), consultation and education activities (*20), and evaluation activities (*21). CMHCs reporting a negative impact due to the block grant were more likely to prefer the categorical method of federal service funding to the block grant method (*22).

The adverse impact of the block grant was felt by aging services.

There were significant differences in the impact of the ADMS block grant on CMHC geriatric programs. Centers reporting adverse effects were more likely than those reporting no adverse effects to have discontinued a program for the elderly between 1981 and 1984 due to funding reductions (*23).

Adverse effects of block grant funding were not related significantly to either whether a CMHC reported having a current program targeting services to the elderly or to the number of aged clients served. Centers indicating adverse effects, however, did report that they had more staff trained to deliver services to the aged (*24), offered a greater number of services as part of their aging programs (*25), and allocated more center funds to geriatric services (*26).

There were no significant differences between centers related to the block grant in terms of services targeted to minority elderly or working relationships with area agencies on aging.

The 1985 findings related to the effect of the ADMS block grant on aging services support the findings of the 1983 Action Committee survey, which found that CMHCs reporting adverse effects (a) had received significantly less federal support than centers reporting no adverse effects, (b) had delivered significantly more services to aged clients in the past (independent of the total number of clients served), and (c) were struggling to maintain ongoing geriatric service programs.

Conclusions Drawn from Mail Survey Data

The 1985 Action Committee survey of community mental health centers found that there is great variability in the geriatric services that are available in different communities and, at the same time, that older adults continue to be underserved by CMHCs. While the overall number of CMHCs offering specialized mental health services to the elderly has not decreased further since the 1983 Action Committee survey, the number of programs designed to meet the needs of the elderly is still insufficient. This is particularly unfortunate in view of the fact that those centers that had geriatric programs were more likely to have staff trained in geriatric mental health and make aggressive efforts to deliver services to the elderly, and they delivered a broader range of mental health services to their elderly clients.

The survey results demonstrate that, on the average, CMHCs received significantly less federal funding after the implementation of the federal ADMS block grant than under the categorical method of funding, and that the decreases have been compounded by a 17.4% rate of inflation. While states have increased their mental health budgets, the amounts allocated for CMHCs have barely kept pace with inflation. The 1981 federal mental health budget, while well below the level needed to support adequate service delivery to the aged, did demonstrate an active federal involvement in providing health services. However, there has been no real dollar increase in federal mental health funding in four years, and the ADMS block grant represents a retreat from active federal participation in mental health service delivery.

The results of the Action Committee survey clearly indicate that the federal block grant method of mental health service funding has failed to fulfill the Reagan Administration's assurances that the consolidation of categorical funding programs into more flexible block grants would stimulate the development of innovative state mental health programs to meet the needs of the aged and other special populations. In fact, in relation to the aged, since the implementation of the ADMS block grant, the opposite has been true.

- Programs designed specifically to provide geriatric services have decreased;
- Staff trained for and assigned to provide services for the elderly have been reduced;
- Funding has been focused on populations other than the aged;
- New programs designed to meet the needs of a growing aged population have <u>not</u> emerged.

In sum, state and local programs are struggling to survive and maintain the status quo; to retain essential programs without further reductions.

Chapter III

SITE VISITS TO COMMUNITY MENTAL HEALTH CENTERS, AREA AGENCIES ON AGING AND SENIOR CENTERS

Summary of Site Visit Findings

Community Mental Health Centers

- CMHCs reported adverse effects on their activities due to block grant funding.
- CMHCs reported little increase in service delivery to the aged.
- The aged continue to be an underserved population.
- The block grant has had a negative impact on geriatric services.
- CMHCs prefer the categorical method of federal service funding to the block grant.
- CMHCs reported a decline in specialized aging programs.
- Few CMHC staff are trained to deliver geriatric services.
- Some CMHCs reported active programs for the aged.
- CMHCs report a small increase in contact with area agencies on aging and senior centers.
- CMHCs want to improve services to the aged.

Area Agencies on Aging and Senior Centers

- AAAs and senior centers offer some mental health-related services and training programs.
- Few AAAs have plans to implement the mental health provision of the Older Americans Act.
- Aging services staff are often aware of the mental health service needs of their clients, but find obtaining such services difficult.
- AAAs and senior centers reported modest interaction with CMHCs.
- AAAs and senior centers want to collaborate with CMHCs in providing mental health services to the aged.

Introduction to the Site Visits

This chapter presents information obtained during on-site visits and interviews conducted with community mental health centers (CMHCs), area agencies on aging (AAAs), and senior centers in selected localities.

The goal of the site visits was to obtain more complete information on (a) mental health services being delivered to older adults; (b) the impact of the block grant method of service funding on community mental health center age-related services; and (c) the nature and extent of interagency contact and cooperation between CMHCs, AAAs, and senior centers, and the impact of interagency collaboration or noncollaboration on agency clients. Accordingly, appointments were arranged by Action Committee staff for two interviews in each site visit locality: one with CMHC personnel and one with AAA or senior center personnel. In several instances, additional interviews were arranged with other direct service, county and regional planning and coordination agencies, and with state departments of mental health.

Selection of Visit Sites

The mail survey questionnaire asked if the respondent would "be willing to participate in a follow-up interview at a later date"; 133 (65%) CMHCs responded positively. Out of these, 26 sites were selected based on the following criteria: (a) CMHCs from each of the country's ten major geographic regions; (b) CMHCs from urban, suburban and rural areas, representing, as much as possible, a range of service delivery strategies; (c) CMHCs with high and low percentages of elderly in their catchment areas; (d) CMHCs reporting high as well as low percentages of elderly served; (e) CMHCs with and without specialized aging programs; (f) CMHCs that reported adverse effects, as well as those that reported positive effects due to the block grant; and (g) only CMHCs where the area agency on aging or senior center within their catchment area would also agree to a site visit and interview.

Using these criteria, 26 locations were selected for site visits. Two AAA directors were unavailable for their scheduled appointments, resulting in only 24 AAA and senior center interviews. Interviews were conducted during the Summer and Fall of 1985 by Action Committee interviewers.

Interview Protocols

To ensure that the data could be compared across all locations, interviewers conducted the interviews using structured interview protocols. To enable CMHC, AAA, and senior center personnel to prepare for the site visits in advance, interview protocols were mailed to the interviewees prior to the site visits.

Community Mental Health Centers. The CMHC site visit interview protocol (see Appendix C) contained five sets of questions. The first set asked the centers to indicate whether or not the Alcohol, Drug Abuse and Mental Health Services block grant had affected their programs, their client populations, service delivery, relationships with other agencies, and relationships with state and local governments. The second set of questions requested information on the prevalence of mental impairment among the elderly in the community, as designated by DSM III diagnostic categories, the major factors that impeded the center's delivery of mental health services to the elderly, and the number and service responsibility of staff trained to deliver mental health services to the

aged. Centers that indicated in the mail survey that they had an aging program were asked to identify the services provided. Centers that had indicated that they had discontinued aging programs were asked to explain why the program had been terminated; what plans they had, if any, to compensate for the program loss; and what was needed to reinstate their aging program. Centers that indicated that an aging program had never been offered by them were asked why one had not been developed and what, if any, did they have for developing one in the future. The third set of questions explored the nature and extent of contact and cooperation between the CMHC and other community-based agencies, requested information on how clients were referred to the center, and asked whether there were other community agencies within the center's catchment area that provided mental health services to the elderly. The fourth set of questions asked centers to indicate which, if any, nonfederal funding sources had been responsive to their needs for support for mental health programs serving older persons, which sources would be responsive to the needs of the center if the federal government continued to withdraw financial support, and whether the CMHC should be the primary agency for the delivery of mental health services to older persons. The fifth part of the questionnaire asked for additional comments about CMHC activities, such as exemplary programs for the delivery of services to the elderly, creative financing, citizen involvement in the activities of the center, examples of good local and state government planning, and issues of local concern, as well as topics that didn't fit the standardized interview format.

The majority of the interviews were conducted with the executive directors of the CMHCs or with the directors/coordinators of their geriatric service programs.

Area Agencies on Aging and Senior Centers. Interviews with AAAs and senior centers were more general in nature than those with CMHCs since the site visits represented the first substantive contact with those agencies. A site visit interview protocol (see Appendix D) was developed that contained six sets of questions. The first question asked for information on the services offered, funded, or contracted by the agency. The second set of questions requested information on the mental health activities of the agency, whether the agency had any mental health professionals on its board of directors or staff, whether any of the services provided were related to mental health, whether they agency planned to implement the new provision of the Older Americans Act to support mentally impaired elderly in the community, whether the agency provided training concerning mental health and aging, whether it had conducted or contracted for an assessment of the need for mental health services among the elderly in the community, what the perception of the agency's staff was of the prevalence of mental impairment among community elderly, whether the presence of mentally impaired elderly presented any problems to the agency's ongoing aging programs, and what staff perceived to be the major impediments to the delivery of mental health services to the elderly. The third set of questions explored the nature and extent of contact and cooperation between the agency, CMHCs, and other community-based organizations, the usual nature of the agency's interaction with other agencies regarding older clients, and whether the implementation of the block grants had affected interagency interaction. The fourth set of questions requested information on agency funding, the impact of funding changes, which nonfederal funding sources had been responsive to the needs for mental health programs serving older persons, and which sources might be responsive to the need for mental health services to older persons if the federal government continued to withdraw financial support. The fifth part of the questionnaire

asked the agency to indicate which community organizations agency staff believed to be most appropriate to provide mental health services to older people. The sixth part asked the staff to add any comments about the agency's activities and services, such as exemplary programs for contacting elderly clients, creative financing, citizen involvement in activities, examples of good local and state government planning, issues of local concern, and topics that didn't fit the standardized interview format.

The area agencies on aging selected for visits were local planning and administrative bodies that did not provide services directly; rather, the services they sponsored were provided under contract by other organizations. The senior centers were multipurpose in nature, with the majority providing a broad range of services to the aged, that included nutrition programs, food distribution, case management, information and referral, Retired Senior Volunteer Programs, transportation services, legal aide, health and mental health classes and screenings, home care and chore services, adult day care, recreational and social programs, and counseling and support services.

The majority of the interviews were conducted with the executive directors of the area agencies on aging and senior centers.

Community Mental Health Center Interviews: Overview of Results

The results of the interviews of CMHC personnel paralleled those of the 1985 mail survey.

Community mental health centers reported adverse effects on their activities related to block grant funding.

The CMHC representatives were asked "How has the implementation of the Alcohol, Drug Abuse and Mental Services block grant program affected your Center?" Thirteen (50%) of the 26 respondents reported a negative impact, 10 (38%) reported no impact, and 3 (12%) reported positive impact.

Those interviewed also were asked to describe how the block grant had affected their centers. The following statements are illustrative of the those received.

> We have less personnel. Persons with training in working with elderly clients had less seniority and thus, with staff reductions, they were the first to go.
>
> Lost 25% of our budget the first year and have not recovered. We lost 20 staff, including our staff trained in gerontology. No longer have programs for children, aged, or in evaluation. We have to use generalists.
>
> Decreased outreach, networking, and home visits. Originally thought that there would be more choice and flexibility with the block grant system, but haven't found that to be so.

> The state initially was able to make up for the loss of federal funds in order to maintain the existing service programs at a reduced level. The reduction was brought about by the change from categorical to block grant funding.
>
> Initially negative because the amount was cut. However, funding has stabilized over the past two years allowing for continued programming, and the ability to plan for future development.
>
> Because the way the CMHC is organized and structured, the block grant had little or no effect on their program. Their focus is on the chronic mentally ill and the block grants are allowing their work to develop.

These findings are consistent with the results of the 1983 Action Committee CMHC site visits, in which 6 (55%) of the 11 centers visited reported a negative impact on their programs due to the block grant, 4 (36%) reported no impact, and 1 center reported mixed effects.

Community mental health centers reported small increases in service delivery to the aged.

The CMHC personnel were asked to indicate whether the composition of their center's client population had increased, remained unchanged, or decreased. There was a mixed response to this question. Some client groups had increased, and others had not changed, but few CMHCs reported decreases in any client population category. CMHCs reported an increase in aged clients in 10 centers, no change in 10 centers, and a decrease in 6 centers. (Some CMHCs reported decreases in two other client populations: children and adolescents in 18% of the centers, and alcohol and substance abuse patients in 14% of the centers).

This data reflects substantial changes since the 1983 Action Committee site visits, when only 1 CMHC reported a decline in the number of aged clients served.

The aged continue to be an underserved population.

In response to the question "What percentage of this center's clients are aged?", CMHCs reported that the elderly made up the following percentage of their caseloads: 1% to 5%, 15 (58%); 6% to 16%, 5 (20%); and 20% to 24%, 3 (12%). Two CMHCs did not know the percentage of aged served in their centers. Of the 3 centers reporting the highest level of aged served (20-24%), 2 had catchment areas with populations comprised of 30% to 50% older adults. Two had active outreach programs and frequent interaction with the area agencies on aging and with senior centers. Two reported active in-home service programs. It is apparent that although some centers actively recruited older clients and provided a comprehensive range of services, many appeared to be making little effort to provide services to the aged.

These findings are consistent with those of the 1983 site visits, in which 10 centers reported that the aged were underserved and only 1 reported that the aged in the community were fully served.

Community mental health centers reported that the block grant has had a negative impact on geriatric services.

CMHC staff were asked "Has the ADMS block grant program had any impact on the provision of mental health services to older people at the center?" Staff of 12 centers (46%) reported a negative impact on mental health service delivery to the aged, 10 centers (38%) reported no impact, and 4 centers (15%) were unsure. The following illustrates the comments received on this question:

> No discrete program for the aged; no incentive.
>
> Decrease in services.
>
> Staff with experience left because of decreased funding. There are decreases in many services and an increased waiting list.
>
> Loss of elderly services coordinator and loss of staff across the board.
>
> There has been a slow, gradual, but steady decline in services to the elderly.
>
> Administrative limitations on program development and revenue generation specifically for elderly services has occurred. Less program outreaching, networking, and home visiting occurs.
>
> The CMHC never cut the amount of money going to aging because of the block grant, its only been in the last year or so that they have thought that they might do that - but, that has been more because of the state grant-in-aid money going down, than due to the block grant.

Those interviewed also were asked whether the decrease in federal funding for mental health services had resulted in the development or exacerbation of any problems related specifically to the delivery of services to the aged. Fifteen centers (58%) reported either no change or a decrease in the number of aged clients served; only 7 centers (27%) reported an increase in services to older adults. Regarding activities and services, 15 centers (58%) reported either no change or a decrease in such aged-related activities as outreach programs, home visits, nursing home visits, consultation and education activities, needs assessment projects, prevention activities, and public information. Only 5 centers (19%) reported increases in these activities, and 1 center (4%) presented a mixed report of increases in some activities and decreases in others.

Overall it would appear that the change in the method of federal funding -- from the categorical to the block grant method -- coupled with a significant reduction in the federal contribution for services has been detrimental to the provision of services to the aged. This has happened in two ways: first, states emphasis on services to populations other than the aged, and second, funding available to local facilities to sustain services to, and programs for, older persons has been reduced.

Community mental health centers prefer the categorical method of federal funding to the block grant.

In response to the question "Does your center prefer the current block grant system of funding to the categorical system used prior to the block grant?", 15 (58%) of the 26 CMHCs preferred the categorical method of federal funding used prior to the ADMS block grant, 4 (15%) preferred the block grant method, 2 (8%) did not indicate a preference, 4 (15%) indicated they were not receiving federal funds, and 1 (4%) indicated "no preference".

The staff being interviewed were asked to elaborate on their preference for either the block grant or categorical funding method. The following comments are illustrative of those received:

> Clearly and primarily because of control given to the state without guidelines. They have gone too far toward state responsibility. There is no uniformity in service delivery or date collection. The majority of money has been designated to the chronic mentally ill. There are so many people who do not fit into the state's narrow category of CMI.
>
> State has been exercising more control. There has been decreased flexibility in how the money can be used. A loss of local control, replaced by state control.
>
> Services are the same, however we can't really expand anything or start new projects unless we are certain that we will be reimbursed for them. This puts older adults on fixed incomes at a disadvantage.
>
> Funding is the biggest obstacle. If categorically funded at federal level, then monies could be used for the elderly.
>
> The block grant method is ok for the chronic mentally ill, but harder on poor non-CMIs. Categorical method gave more freedom to meet community needs and provided a leverage point against the state, which wanted to first empty the hospitals.
>
> The fiscal maintenance of records is now easier, as well as the reporting of activities.
>
> The block grant isn't necessarily the problem, it shouldn't be blindly applied, and states should be required to maintain necessary programs. The problem is the cut in funding.
>
> Prefer the block grant in theory but not in the way it is being implemented. The program should be to serve the people, but the priorities are not based on that concept at the state level. CMHC directors have no say as to mental health priorities at the state level. The block grant saved our lives in that it equalized and stabilized distribution of monies. Now we get more than through the categorical grant funding.

Community mental health centers are aware of the mental health service needs of the aged.

Recent efforts by CMHCs to identify the mental health needs of older adults have been limited. Only 5 CMHCs (19%) had conducted a formal assessment of the mental health needs of older adults in their catchment areas within the previous 2 years Five centers (19%) had conducted partial assessments to identify the needs of patients with Alzheimer's disease and of residents of board and care homes. One center (4%) was preparing to conduct a needs assessment. All respondents, however, offered informal assessments -- based on their experiences and contact with other agencies — regarding the prevalence and nature of the mental impairments experienced by older persons in their communities. The most prevalent impairments cited included depressive disorders, organic brain syndromes and dementia, anxiety disorders, adjustment disorders, medication interaction disorders, alcohol and substance abuse, and family and marital problems. Elder abuse, paranoid disorders, and schizophrenic disorders were reported to be less prevalent. Although informal, these findings are consistent with research findings on the incidence and prevalence of mental disorders in the elderly.

Community mental health centers reported a decline in specialized aging programs.

Although CMHCs recognized the need of mental health services for the aged, they reported a decrease in the number of specialized programs designed to deliver such services to the elderly in their communities. Of the 25 CMHCs, only 11 (42%) had active aging programs; 10 (39%) reported having had aging programs that were discontinued because of funding reductions resulting from the block grant and because of a shift in state-designated priorities to serve other populations; and 5 (19%) reported that they never had a program specially designed to serve the elderly. CMHCs that had discontinued their aging programs indicated a desire to reactivate their programs if funding and staff could be restored.

The 1985 data revealed a significant decrease in the number of specialized aging programs since the 1983 survey. Of the 11 CMHCs visited in 1983, 9 (82%) reported that they had active programs and only 2 (18%) had discontinued programs.

Asked if there were other community agencies within their catchment area providing mental health services to older adults, 14 CMHCs (54%) reported that there were some alternative service delivery agencies for the aged, but 12 CMHCs (46%) reported that there were no other service delivery programs in the area. The alternative service delivery agencies most frequently cited included Jewish Family Services, family counseling programs, psychiatric facilities, senior center counseling services, health maintenance organizations, church programs, and services for special groups (e.g, the mentally retarded). While these agencies undoubtedly contributed important services to their elderly clients, their small size and limited ability to deliver comprehensive services could not compensate for the general lack of services available to the aged through the CMHC system.

Many factors contribute to the underservice of the elderly.

In addition to funding reductions and state priorities for services to other populations, CMHCs cited the following as significant agency barriers to the delivery of geriatric mental health services: staff reductions, lack of staff trained in geriatric services, increased client waiting periods for services, and a lack of outreach programs, home-delivered services and transportation programs. They also cited the negative stereotype and stigma often associated with "mental illness" by the aged and the lack of demand for, and utilization of, services by the elderly as barriers to service delivery.

Few mental health center staff are trained in geriatric services.

In response to the question on how many center staff were specifically trained in the provision of mental health services to the elderly, 9 CMHCs (35%) reported having no staff trained in geriatric mental health services and 1 (4%) center had a half-time staff person. Three centers (12%) had 1 full-time staff member, 3 centers (12%) had 2, 5 centers (19%) had 3 staff, 4 centers (15%) had more than 3 staff members (one of these had 26 trained staff). One center (4%) could not provide information on the training of staff. Six centers reported a decrease in the number of staff trained in geriatric mental health due to budget reductions.

Community mental health centers reported a small increase in contact with area agencies on aging, senior centers, and other community agencies.

CMHCs with aging programs reported some increase in contact with area agencies on aging and senior centers. Of the 26 CMHCs visited, 8 (30%) reported frequent interaction with the aging services network, 9 (35%) reported monthly contact, and 9 (35%) reported infrequent or no contact. This data reflects an increase in interaction since the 1983 site visits, when CMHCs reported little routine contact with the area agencies on aging. There was considerable variation in the interaction with other community agencies. Ten CMHCs (38%) reported daily or weekly contact with many agencies, 11 (42%) reported monthly or infrequent contact with some agencies, and 4 (15%) reported almost no contact with any other agencies. There was no correlation with size of community or location in an urban or rural area -- some small CMHCs were closely linked with many agencies, while others in large cities had very little contact with any other agencies.

CMHCs with specialized aging programs and frequent interaction with the aging services network reported regular client referrals from those organizations. Other sources of referrals included center outreach efforts, families, self referral, and, less frequently, referrals from physicians and health-care personnel.

In addition to referrals, CMHC interaction with other agencies frequently included a full range of services to the aged: assessments and screenings, inpatient and outpatient services, clinical consultation, and discharge planning. Other services included case management, advocacy, and administrative activities. The block grant was not perceived as having had any impact on the nature of CMHCs' interaction with other agencies.

Funding and the structure of service delivery will effect future directions taken by community mental health centers.

On the part of CMHCs, there is a universal lack of confidence in the probability of the private sector providing financing that will replace decreases in federal funding. They also did not believe that state and local governments would be able to support their programs if federal funding continued to decrease.

Twenty-three centers (88%) responded in the affirmative when asked whether the CMHC should be "the primary agency for the delivery of mental health services to older persons". These respondents expressed a desire to improve services and a frustration at the lack of resources to do so. The following comments are illustrative of those received on this question:

> We can provide more direct hands-on services quicker. The problem is our being a mental health facility - Jewish Family Services doesn't have the same stigma.
>
> Centers should be a resource to the total community. Should be a strong federal mandate and not leave care to the whim of the state. Services should be uniform nationally -- a national standard -- with no local axes to grind.
>
> Just give us the means. This state will not do it until the federal government says so.
>
> The CMHC is the best equipped, located conveniently, has trained personnel. There is a tendency to underprovide for the elderly.
>
> The CMHC seems to be the most appropriate and only community focal point for such services.
>
> We have the capacity and responsibility for the delivery of "primary" services such as diagnosis and direct clinical intervention.
>
> We're the persons in the business! We are perceived as a community resource. The problem is we will be inundated with requests for services from aged clients in five years and we're not preparing for it.

Three centers responded that other agencies should cooperate in service delivery and that CMHCs should not necessarily be the primary agency for service delivery to the aged. At the same time, they indicated that CMHCs should have an active part in the delivery of mental health services to older adults. The following are examples of comments received:

> The area agency, with the cooperation of the CMHC, should be the vehicle for the delivery of mental health services. The important thing is not to duplicate services.

> Dwindling resources from various sources, will require that other agencies, including private and public ones, must participate in mental health care and services for the elderly. The CMHCs will not be able to do it by themselves under present funding and resource conditions.
>
> Should work with other agencies which go into the home. There is still a reluctance for older people to go to the CMHC.

The responses to these questions on future directions are consistent with those received during the 1983 Action Committee site visits.

Area Agency on Aging and Senior Center Interviews: Overview of Results

Area agencies on aging and senior centers offer some mental health-related services and training programs.

Although only 10 (42%) of the 24 aging services organizations interviewed had any mental health professionals (psychiatric nurses specialists, psychiatrists, psychologists, social workers) on staff, and only 12 had any on their boards of directors, the majority of the AAAs and senior centers offered services that were mental health in nature. Either directly or through contract, 20 (83%) provided services such as case management, information and referral, telephone reassurance, widow and widower counseling, and crisis intervention. Some organizations offered grief counseling, Alzheimer's disease support groups and day care, caregiver support groups, and escort services. The 20 aging organizations that provided training in mental health and aging did so through in-service programs and the distribution of educational materials. A few organizations described vigorous on-going training programs for health professionals and home-care staff, in-service programs with local university departments, regional training conferences, and internship programs.

Few area agencies on aging and senior centers are aware of, or have plans to implement, the mental health provision of the Older Americans Act.

The 1984 reauthorization of the Older Americans Act (P.L. 98-459) contains a provision for grants to states for:

> Services designed to enable mentally impaired older individuals to attain and maintain emotional well-being and independent living through a coordinated system of support services.

At the time of the interviews in 1985, staff of several of the selected AAAs and senior centers were unaware of the mental health provision of the Older Americans Act. Of those who were aware of it, 13 of those interviewed indicated that they were planning either full or partial implementation of the provision, and stated that it would allow them to provide more needed services.

Respondents that indicated their intention to implement the mental health provision expressed a desire to improve and expand the services they delivered. The following comments are illustrative of those received on this item:

> We plan to hire a social worker or a staff development person to train AAA staff in case management.
>
> Our plans for an Alzheimer's disease support group apply here. But we don't want to start a program that won't be supported later.
>
> We plan to use the old hotel for placement of older deinstitutionalized patients from the state hospital. Meals and case management will be provided.
>
> Hope to purchase a VCR and set up a lending library. Plan to develop training and support for caregivers and for elderly with mental health problems.
>
> Will establish telephone reassurance program and the placement of a CMHC counselor in an office at the multipurpose center.
>
> Want to get more aggressive -- may not have AoA funds to implement, but will ask for more funding.
>
> If the funds become available we will implement a program of services for mental health care.

Six organizations that were aware of the mental health provision of the Older Americans Act indicated that they had no plans to implement the provision. The following are illustrate the comments received:

> We are doing some informal work with alcoholics and CMIs already.
>
> We had some plans to work with the CMHC with frail elderly and Alzheimer's disease cases, but these plans won't be implemented because of drops in funding.

<u>Aging services staff are often aware of the mental health service needs of the aged, but find it difficult to obtain services</u>.

While only 6 (25%) of the area agencies on aging and senior centers had conducted a formal needs assessment within the past 2 years, most were aware of mental health problems among their clients and felt that the mentally impaired elderly in their communities were not being adequately served. The categories of mental impairment most frequently cited included depression, family and marital problems, social maladjustment, alcohol abuse, anxiety, and medication interaction disorder. Several centers added social isolation and loneliness as disorders. Elder abuse, organic brain syndrome, and dementia were reported as being much less prevalent. Staff of the aging agencies characterized their clients with mental health problems as those with chronic health problems, widow and widowers, and residents of board and care homes. Only a few agencies reported that homeless or deinstitutionalized patients were among their clients.

The few meals-on-wheels programs and senior center nutrition sites that identified clients with mental impairments as disruptive to their programs reported that such problems were infrequent. However, some special care needs were cited:

> We have worked to gain acceptance of those with mental health disorders by both staff and other clients. We don't exclude clients because they act strange or different. We do have a policy of not allowing people to attend when they are drinking -- no drinking on the premises.
>
> There is a need for in-house diagnosis and assessment for isolated, frail people. Need places to refer people -- there is a gap in services, except for institutionalization.
>
> We have a Saturday Socialization Program for deinstitutionalized elderly. There are few disruptions with our Community Program adults.
>
> Agency needs to upgrade staff to handle problems. The agency needs more professional help.

Area agencies on aging and senior centers cited the following as major factors that impede the delivery of mental health services to the elderly: CMHC staff reductions, lack of staff trained in geriatric services, reduced funding, negative attitudes of mental health staff toward the aged, and the lack of transportation, home-delivered services, and outreach programs. Additional barriers were: the aged were not considered a priority for services; cost of services to the client; CMHC bureaucracy introduced impediments, culture and language presented barriers for minority clients; and the dumping of the aged into nursing home limited the access of the aged to mental health services. Other significant barriers to service delivery cited were the elderly's attachment of a negative stereotype and stigma to "mental illness," their lack of demand for and utilization of services, and their lack of knowledge about mental health services.

Area agencies on aging and senior centers continued to report little interaction with community mental health centers.

Consistent with the findings of the 1983 Action Committee site visits, only 6 (25%) of the 24 aging organizations interviewed reported weekly (or more frequent) interaction with CMHCs, 12 (50%) reported monthly contact, and 6 (25%) reported no contact. Eight organizations reported having a formal agreement or contract with one or more CMHCs for such services as transportation, in-service or joint training programs, and consultation and education activities. Contact also included the cosponsorship of workshops and conferences, attendance at occasional events or meetings, dissemination of mental health information, and referrals. Only a few aging organizations shared facilities with CMHCs or joined CMHCs in planning, sharing of funding for services, or maintaining representation on one another's advisory boards.

While interaction with CMHCs was generally infrequent, AAAs and senior centers did report frequent contact with such non-mental health human services organizations as welfare offices, board and care homes, nursing homes, and other AAAs and senior centers. Contact was usually related to referrals for services,

advocacy, discharge planning, and case management, rather than to ongoing care. Although several AAAs and senior centers noted increased interaction problems due to budget reduction and staff cuts sustained by other agencies, overall an increased sense of interagency cooperation was noted as a result of reduced budgets. Agencies appeared to be relying increasingly on each other for coordinating service delivery.

Funding changes have been experienced by area agencies on aging and senior centers.

None of the aging organizations interviewed had sustained an overall loss in funding over the previous two years, but they had experienced shifts in the sources of funding. The AAAs reported that funds provided under the Older Americans Act had remained constant or increased, but that funding from other federal sources had decreased. Several AAAs commented that although the dollar amount of their budgets had increased, they were still underfunded in proportion to the number of aged in the community who needed mental health and other services, and that it was fallacious to assume that the private sector could compensate for federal budget freezes and funding reductions. Senior centers reported considerable fluctuations in funding and that they had turned increasingly to the United Way, local government, increased client fees, and membership dues for support for their programs.

Area agencies on aging and senior centers want to cooperate with community mental health centers in the delivery of geriatric mental health services.

In response to the questions about which community organizations were the most appropriate to provide mental health services to older people, 14 (58%) of the 24 aging organizations visited designated CMHCs as the appropriate primary agency, 4 (17%) designated AAAs and senior centers and 6 (25%) designated other organizations. As secondary sources of mental health care, 8 (33%) aging organizations designated AAAs and senior centers. The aging organizations commented that CMHCs have the staff and training to provide mental health services, but that there should be more cooperation between the mental health and aging services networks in service delivery. This interest in cooperative service delivery represents a significant change in attitude since the 1983 Action Committee site visits; at that time, AAAs expressed little interest in actively participating in the delivery of mental health services to their clients. The following are illustrative of the comments received:

> Mental health services should be delivered at the senior center. Because of the stigma problem it is difficult to get people to go to the CMHC.

> Area agencies on aging and senior center should be sites -- provided they had professionally trained personnel. Since we have a high concentration of poor, rural, Black population, what we need is more committed, professionally trained Blacks to develop more meaningful programs in mental health for residents.

CMHCs seem to be the best organizations because they have appropriately trained personnel. However, AAA should be in a cooperative relationship with them. Social services cannot be separated from mental and spiritual well-being of older persons.

The CMHC with AAA participation.

Would like to see senior centers utilized better -- would need experienced counselors coming in to provide services.

People come to the center on a regular basis, it is logical to have services on-site. People are comfortable with the setting and staff. It would decrease the "institutional" aspect of service delivery.

Conclusions Drawn from Site Visit and Interview Data

Data obtained during site visits and interviews with community mental health centers, area agencies on aging, and senior centers generally supported the mail survey findings reported in Chapter II. Community mental health centers reported that the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant has had a negative impact on CMHC aging programs, that a lower amount of funds were available for services to the elderly, and that priorities for services have been directed toward client populations other than the aged. CMHCs also reported that the decrease in funding for aging services has resulted in reductions in the number of staff members trained in geriatric mental health service delivery, a decrease in specialized aging programs, and an inability to expand outreach and service delivery programs to meet the requirements of such special need groups as the homebound elderly.

There were also some notable exceptions to the overall pattern of retrenchment. Even with the reductions in federal ADMS block grant funds, some state aging and mental health departments did allocate funds to promote active aging programs. This was true in states where active programs existed prior to the implementation of the ADMS block grant, where there were state-level staff with experience in mental health and aging, and where there was advocacy on behalf of programs to meet the mental health needs of the elderly.

No examples were found of CMHCs being able to develop active geriatric programs without state support, and few states had developed aging programs without some federal involvement through grant or demonstration project funds.

Between the 1983 and 1985 Action Committee site visits, area agencies on aging and senior centers reported that there had been an increase in the mental health-related services they offered to their clients. Several agencies had recently added counselor/case managers to their staff and were beginning to address the problems of normal aging and life transitions, bereavement, and retirement issues. They were cognizant of the more severe mental health problems of some of their clients, and they indicated a desire to work more closely with CMHCs to improve service delivery to the aged.

There has been some increase in interaction between CMHCs, AAAs, and senior centers since the 1983 Action Committee site visits. CMHCs indicated increased interest in providing services to the aged. AAAs and senior centers

demonstrated an increased awareness of the mental health needs of the aged, as well as a desire to work cooperatively with CMHCs in improving mental health service delivery.

The Action Committee believes that it is crucial for the well-being of the elderly that the aging services and mental health networks develop and implement cooperative working agreements for the delivery of mental health and social services to the aged. Cooperation between these service networks, at the local level, should be encouraged and facilitated by state and federal governments.

Chapter IV

FINDINGS AND RECOMMENDATIONS

Major Findings

The block grant continued to have a negative impact on community mental health center services.

Thirty-seven percent of the community mental health centers (CMHCs) responding to the 1985 survey reported adverse effects on their service programs due to the block grant method of federal funding and its accompanying reductions in federal support for mental health programs. The effects were reported nationwide and were not limited by geographic region. The adverse effects, due to reductions in federal funding and state emphasis on non-aged populations, included decreases in clinical staff, outreach programs, in-home services, and consultation and education activities.

The aged remain a population that is underserved by both public and private mental health systems.

The aged in our population continue to be severely underserved by both public and private mental health systems. Although the aged comprise 12% of the national population, and may require mental health services at an even higher rate than their demographic level may indicate, they receive only 6% of CMHC services, and an even smaller portion of services from private mental health programs and practitioners. Although it has been demonstrated repeatedly that many of the aged are in great need of mental health services, and that they can benefit significantly from appropriate services, the reductions in federal funding and state mental health priorities that have resulted in services being targeted to other populations have inhibited the growth and maintenance of programs to adequately meet their mental health needs.

The block grant continued to have a negative impact on geriatric mental health services.

The reduction in support for mental health services has had a negative effect on specialized aging programs. This is unfortunate, since it has been demonstrated that CMHCs with designated aging programs have delivered significantly more geriatric services than those without such programs. While the 1970s was an era of expansion in specialized aging programs, the 1980s -- the period following the implementation of block grant funding -- has been an era of retrenchment and termination of many geriatric programs. The 1985 Action Committee survey demonstrated that the trend of deterioration in aging programs is continuing. Virtually no new specialized aging programs have been initiated since the implementation of the block grant approach to federal service funding.

Some improvement was reported in interagency cooperation between the mental health and aging services networks.

In both the 1983 and 1985 Action Committee studies, although CMHCs often

reported regular interaction with area agencies on aging and senior centers, there were few contractual agreements for service delivery between any of these organizations and little cooperative interaction in planning, development, resource allocation, and delivery of mental health and psychosocial services to the aged. Although some progress has been made in this direction, little emphasis is placed on strengthening interagency cooperation and collaboration in the delivery of geriatric services.

Staff of community mental health centers are inadequately trained in geriatrics.

Forty-one percent of the CMHCs surveyed reported that they had no staff members trained in geriatric mental health. Overall, only 5% of staff had training in geriatric services. The professional training of CMHC staff frequently has not included coursework in the mental health needs of older adults or the treatment methodologies appropriate for use with older clients. In-service training programs often neglect the problems of, and services to, the aged. As a consequence, mental health professionals often are not knowledgeable about geriatric treatment and tend to avoid working with elderly clients.

Staff of area agencies on aging and senior centers are inadequately trained in mental health.

Staff members of area agency on aging and senior centers rarely have training related to the mental health needs of the elderly. Although staff are knowledgeable about the health, nutritional, housing, social, and recreational needs of the aged, they have received little or no formal preparation in recognizing mental disorders and making referrals for mental health services. As a consequence, the mental health needs of the elderly often are not recognized and, therefore, remain untreated. In-service training programs, as well as collaborative efforts between the aging services and mental health networks are needed.

Recommended Federal Reforms

In response to the survey and site visit findings and the mental health recommendations of the 1981 White House Conference on Aging, the Action Committee recommends the following federal reforms to improve mental health services for the aged.

Recommendation 1

Abolish the block grant method for the funding of mental health services.

A major limitation of the block grant approach to funding with respect to the elderly is its lack of requirements for the uniform availability of services on a nationwide basis. Although the block grant system does include some provision for specialized geriatric services, this provision has not been consistently implemented. States are left to develop their own priority areas for mental health funding, with the result that services to the aged have often been neglected. There has been considerable variation among states in the quantity and types of targeted services provided for the elderly, and the block grant provides little incentive to CMHCs to develop innovative service delivery

programs designed to meet the mental health needs of the aged. Thus, the elderly have remained a severely underserved population within the CMHC system.

Recommendation 2

Reenact the Mental Health Systems Act of 1980, including a categorical system of funding for geriatric mental health services.

The Mental Health Systems Act (P.L. 96-398) identified the elderly as a population for special attention in order to ensure access to services through grants to states for the location of older individuals in need of mental health care (including those in nursing homes); to improve the training of staff to work with the aged; and to provide mental health and support services. This Act would help to create a national priority for uniform planning, development, and delivery of mental health services. It could also encourage the establishment of partnerships between governments at the federal, state, and local levels that are necessary if mental health services are to be provided to unserved and underserved target groups.

Recommendation 3

Expand Medicare mental health coverage to a level that parallels medical benefits coverage.

The Congress should eliminate Medicare's institutionalized bias against those suffering from nervous and mental disorders, and provide coverage that is equal to that available for physical disorders. The following Medicare revisions are recommended:

a. The reimbursement ceiling for mental health services, which is currently at $250, should be eliminated since there is no ceiling for physical health care.

b. The Medicare Part B co-insurance requirement for mental health care should be decreased from 50% to 20% for the recipient, as it is for physical health care.

c. Outpatient mental health services should be made more accessible to the elderly by expanding the definition of mental health treatment providers who can be directly reimbursed to include all of the four core mental health professions (psychiatric nurse specialists, psychiatrists, psychologists, and social workers).

d. The 190-day lifetime limit on inpatient treatment for nervous and mental disorders should be abolished since there is no lifetime limit for physical health care.

Recommendation 4

Amend the Older Americans Act to ensure coordination between state agencies on aging and state departments of mental health, and between area agencies on aging and community mental health centers in meeting the mental health and psychosocial needs of the elderly.

This recommendation is intended to encourages linkages between the aging services and mental health networks for the delivery of services to the aged. Title III of the Older Americans Act should be amended to authorize area agencies on aging to make grants related to the social needs of the mentally impaired elderly. Area agencies on aging should be directed to develop working agreements with community mental health centers, and other organizations providing mental health services, in order to assure coordination in meeting the mental health and social needs of the aged. A separate appropriation should be provided for the operation of such programs rather than requiring area agencies on aging to operate such programs out of existing funds. In addition, state agencies on aging and area agencies on aging should be directed to implement the current mental health provision under Title III of the Older Americans Act.

Recommendation 5

The federal government should take administrative action, as necessary, to ensure that the existing interagency agreement between the National Institute of Mental Health (NIMH) and the Administration on Aging (AoA) mandating mental health and aging service systems cooperation in the development and provision of psychosocial services to the elderly be implemented in an expeditious manner.

Both NIMH and AoA are administered by the Department of Health and Human Services (DHHS) so that agreements for the coordination of services can be developed and supervised through the initiative of the Secretary and Assistant Secretaries of DHHS, by the Commissioner on Aging, and appropriate administrators, directors and division chiefs.

In addition, AoA and NIMH should actively promote the development of interagency agreements at the state and local levels. State agencies on aging and state departments of mental health should coordinate their planning, development, and delivery systems to provide psychosocial services to the elderly. These efforts would be in addition to, but supportive of, the local CMHC and AAA activities referred to in Recommendation 4.

Recommendation 6

The federal government should ensure that present and future geriatric mental health personnel needs are being met through clinical and research training programs supported by the Department of Health and Human Services, the Veterans Administration, and other Departments and agencies that serve the aged.

The shortage of mental health personnel trained in service delivery constitutes a critical national problem and, therefore, must be addressed at the national level. Concerted efforts are needed to train both students and faculty of schools of nursing, psychiatry, psychology, and social work in geriatric mental health services. Clinical training, program development, and faculty development funds should be used by professional schools and departments to: (a) insure that the core education of all students includes a greater focus on the problems of older persons, (b) develop a greater number of specialized courses in geriatrics, (c) expand supervised practicum opportunities in geriatric mental health service delivery, (d) expand continuing education opportunities in mental health services to older persons, (e) encourage mid-career respecialization in geriatrics, (f) develop programs to reeducate existing faculty in geriatric services, and (g) increase the number of new faculty with expertise in aging within professional departments.

In addition, the Title IV programs of the Older Americans Act for the education and recruiting of personnel for careers in aging should include the recognition of geriatric mental health disorders and methods of referral for service as part of the training activities.

As research increases our knowledge of the aging process and associated physical, psychological, and mental health factors, it is important that research training opportunities in geriatrics and gerontology also be vigorously supported through grants, training fellowships, and career development awards.

Recommended State Reforms

The Action Committee recommendations the following reforms at the state level to improve the delivery of mental health services to the aged.

Recommendation 7

States should allocate their service funds in a manner that ensures that the mental health needs of the aged are adequately addressed.

Under the federal block grant method of service funding, states determine their own priorities for service delivery. Therefore, it is incumbent upon the states to ensure that the mental health needs of the aged are adequately addressed through community mental health centers.

Recommendation 8

State agencies on aging and state departments of mental health should take administrative action to ensure coordination and cooperation in their planning, development, resource allocation, and delivery of service, in order to develop and support an adequate continuum of psychosocial services to meet the diverse needs of older adults.

Such coordination at the state level would serve to encourage similar efforts between local aging networks and mental health organizations. The mental health component of this initiative might include the development of mental health services in long-term care facilities and of mental health outreach programs for the functionally impaired and homebound aged, and improved mental health service delivery to the poor and minority elderly. In addition, cooperative working agreements at the state level would more effectively encourage the exchange of knowledge and technical assistance, as well as joint financing of needs assessments, geriatric programs, and in-service staff training.

Recommendation 9

State governments should enact legislation to establish programs specifically targeted to the mental health needs of the elderly in all state mental health systems.

Currently, under the block grant system, states determine the priorities for services through the CMHCs. While they can adjust mental health service priorities through administrative action, it is recommended that state legislatures mandate and ensure, by force of law, the delivery of a full range

of services to the elderly, and other special needs populations. The legislation should also require the establishment of specialized aging programs throughout the community mental health centers system.

Emphasis should be given to the delivery of badly needed mental health and psychosocial services to minority and rural elderly since these group are particularly vulnerable and underserved segments of the aged population. In addition, state legislatures should give special attention to the development of meaningful affirmative action programs for the recruitment, hiring, training, and promotion of minority staff and professionals by aging and mental health agencies at both the state and community levels.

Recommendation 10

The directors of state agencies on aging, state departments of mental health, and directors of local area agencies and community mental health centers should assume an active role in advocating for the development of comprehensive mental health services for older adults -- and take the issue before state legislatures, the Administration, and the Congress.

Many directors are already active and effective advocates on behalf of services for the aged. However, the mental health needs of the elderly, in particular, should be strongly emphasized before those governmental bodies responsible for determining that adequate services are funded and made available and accessible to the elderly.

Recommendation 11

States should restore and maintain full mental health funding under Medicaid at the 1981 level (with allowance for inflation) and change the Medicaid eligibility requirements so that all older persons below the poverty level will be eligible.

Many states have reacted to budget reductions by decreasing mental health coverage under Medicaid. Such action tends to discriminate against those poor who are mentally impaired and those for whom alternate treatment does not exist or is not accessible. This trend should be reversed so that state Medicaid plans are able to provide needed inpatient and outpatient mental health services for low income elderly through CMHCs and other public and nonprofit mental health systems. In addition, the Medicaid eligibility requirements should be modified so that all older persons below the poverty level will be eligible.

Recommendation 12

State agencies on aging and state departments of mental health should initiate in-service training programs in mental health and aging at the state and local levels for mental health and aging service staff.

It is recognized that service providers may wish to help older clients, but that they may lack knowledge about the specific needs and problems of the aged. It is crucial that mental health staff be trained in geriatrics and that aging services staff receive training in how to recognize the mental health care needs of the aged. In-service training programs might include a coverage of topics such as: the most common and serious mental health needs and problems of the elderly (including those of the functional but "at-risk", homebound, physically

handicapped, nursing home elderly); appropriate intervention strategies and techniques that might be employed with the mentally impaired elderly (and their families); the range of geriatric mental health services that are available on a state and county basis; and effective techniques that mental health and aging organizations might use in improving intersystem referrals, interaction, and cooperation.

It is recognized that severly reduced federal support for both gerontological and clinical training will exacerbate the already existing shortages of professionals that are available to assist in training programs. It is, therefore, important that a cadre of expert and knowledgeable trainers be developed as quickly as possible. Federal and state governments should cooperate in jointly funding programs to produce a core of aging and mental health professionals who, in turn, would be able to develop additional personnel. On a short-term basis, this would allow some existing agency staff to become better informed about the needs and problems of the elderly and the services that they require. Title IV (the Older Americans Act) training funds should be used to prepare this cadre of trainers.

For long-term mental health and psychosocial planning, both state governments and the federal government should recognize that even the most conservative projected increases in the number of older persons in this country will require significant increases in the trained personnel that are available on the local level to meet their needs.

Recommended Local Reforms

The Action Committee recommends the following reforms at the local level to improve the delivery of mental health services to the aged.

Recommendation 13

Local area agencies on aging and community mental health centers, and other mental health and aging service providers, should initiate formal intersystem interaction and coordination for the assessment, planning, development, and delivery of comprehensive mental health services to the aged.

Beyond federal and state government initiatives, formal working agreements between mental health and aging services systems must be established at the local level, because cooperation at the local level is crucial to insuring that older adults will receive equitable treatment from the aging and mental health service networks.

Recommendation 14

Community mental health centers, and other public and privately funded mental health systems, should establish outreach programs to ensure that adequate and suitable services are delivered on an equitable basis to the aged -- particularly to the minority elderly in the community.

The elderly represent approximately 12% of the overall population and may require mental health services to a degree greater than their demographic representation; however, the elderly generally receive only 6% or less of CMHC services. Adequate delivery of services should include innovative mental health

outreach efforts to reach those elderly not reached by traditional mental health services, those in nursing homes and other long-term care facilities, the homebound and functionally impaired, those residing in rural areas, and members of poor and minority groups. It is recognized that older adults present a difficult challenge to the mental health system in terms of the delivery of services because of the way in which the system is presently organized. Nevertheless, the underserved and unserved elderly must be helped through special and innovative programs and, possibly, through restructuring of the present delivery system (some model programs are included in Chapter V).

The CMHCs should identify and assess the mental health needs of the racial and ethnic minority aged in their catchment areas and develop prevention, treatment, and outreach programs designed to meet their particular needs. In addition, to improve the acceptance and utilization of mental health services by ethnic elderly, minority and bilingual staff and professionals should be trained and employed in treatment centers, and facilities should be located in or near the ethnic community. Outreach efforts should involve already existing ethnic organizations (e.g., churches, community groups). Mental health service personnel should develop an understanding of the cultural backgrounds, values, and beliefs of the different racial and ethnic groups that they serve, and develop expertise in culturally relevant treatment modalities.

Recommendation 15

Local aging networks and mental health systems should initiate joint training sessions for mental health and aging service providers at the community level.

In-service training sessions could serve to stimulate intersystem interaction and exchange of information on such topics as cross-system referrals, psychological and social needs of the elderly, and specific training in geriatric service delivery. Cooperative training efforts well might serve as a critical point of contact to encourage information exchange among service systems and heighten the awareness of the needs and problems of the aged. It also would encourage mutual awareness and appreciation among agencies of the need for the services that they provide and help to reduce the isolation that characterizes the aging services network in many communities.

Recommendation 16

Joint case management systems involving both the aging and mental health service networks should be developed at the community level.

As related to the elderly population, case management may be defined as the coordination of needed services on behalf of the elderly client, including development, implementation, and review of individual service and treatment plans (Mental Health and Aging Advisory Group, 1983). The implementation of an effective case management system would help to ensure that the elderly will receive appropriate and needed mental health and social services. It would also serve to stimulate the development of a client management record system to facilitate follow-up after referrals among agencies, as well as encourage routine inter-staff consultation and cooperation in dealing with client problems.

It is recognized that the effectiveness and operational characteristics of a given case management system will depend on the organizational history and the

availability and strength of community resources. Some communities may draw on resources such as a Community Action Program in assisting the elderly in need of mental health and related services, while others may prefer to use the area agency on aging or the department of human and social services.

Recommendation 17

Interagency community action networks should be established at the local level to develop cooperative planning and program development for a continuum of mental health services for the aged.

The objectives of the action networks might include: increasing recognition within community agencies and programs of the mental health needs of the aged; acting as advocates on behalf of such needs; helping to make the needs understood by decision-makers at the local, state, and federal levels; and identifying strategies to effectively and cooperatively meet these needs (Mental Health and Aging Advisory Group, 1983). The action networks might include representatives from organizations such as: area agencies on aging, community mental health centers, departments of social service, public health departments, hospitals, religious institutions, legal services, the judicial system, institutions of higher education, and other entities interested in the problems of older adults.

In addition, it is recommended that community mental health centers and area agencies on aging have reciprocal representation on advisory and planning boards, and on boards of directors. This would help ensure that the mental health and psychosocial needs of the aged are addressed by each agency.

Chapter V

MODEL PROGRAMS

After the publication of the 1983 survey and site visit results (Flemming, et al, 1984), the Action Committee received many requests from community mental health centers and other interested agencies for information about programs that were successful in delivering mental health services to older persons. This reflects the continuing and, indeed, increased interest in improving mental health services to the aged. The five "model" programs described below demonstrate successful efforts to deliver mental health services to the aged. These programs are representative of the innovative and productive efforts that have been developed at both the state and local levels.

The five initiatives described are:

- Interdepartmental Cooperative Agreements at the State and Local Levels, Commonwealth of Pennsylvania
- Building Ties: A Mental Health and Aging Project, State of Michigan
- Systems Integration at the Program Level: Aging and Mental Health, Spokane, Washington
- Senior Outreach Services, Ventura County, California
- Greater Southeast Multi-Service Senior Center, Washington, D.C.

Interdepartmental Cooperative Agreements at the State and Local Levels The Commonwealth of Pennsylvania

The State of Pennsylvania is taking an active leadership role at the state level to identify service delivery barriers and to undertake policy initiatives to improve the delivery of services to older adults with mental health problems. The initiative to improve services to the aged includes several components: (a) an interagency cooperative agreement between the Departments of Aging and Public Welfare and the Office of Mental Health; (b) the development of written inter-agency agreements on the local level between county area agencies on aging and county mental health programs; (c) the funding of six local model research demonstration projects to facilitate positive working relationships between the aging and mental health systems; (d) the funding of five regional aging and mental health conferences to provide a forum for aging and mental health program administrators and staff to collaborate on service delivery issues; and (e) the funding of a state level needs assessment on services to the aged.

It is beyond the scope of this summary to adequately describe each of these initiatives. This report will, therefore, focus only on the interagency agreements developed at the state and local levels. Information on the other initiatives may be obtained by writing to the contact person listed at the end of this section.

In May 1984, the State of Pennsylvania initiated a three-year interdepartmental cooperative agreement between the Department of Aging and the Department of Public Welfare, Office of Mental Health. The purpose of the agreement was to (a) require the agencies providing treatment, care, and community services to older persons with mental health problems to establish working relationships at the state and local level that would increase the efficiency and effectiveness of their combined efforts, make aging services more accessible to older persons, and (b) to increase the Departments' mutual planning, resource allocation, data collection, and training efforts. The departmental working agreement outlined the responsibilities of each agency in the following areas:

1. Maintenance and improvement of ongoing coordination efforts in the state's Domiciliary Care Program, in long term care preadmissions assessment, in "shared clients" demonstration programs, in personal care boarding homes, in mutual staff training, and in implementing a comprehensive needs assessment.

2. Exploration of additional cooperative efforts in areas of mutual interest: resource sharing on behalf of nursing home patients, promotion of informal support systems, and cooperative use of in-home services.

3. Establishment of local agreements between the area agencies on aging and county mental health offices pertaining to the responsibility for shared clients, the development of a local needs assessment, cooperation in efforts in the program areas listed in items 1 and 2, cooperation and coordination in service delivery at designated sites, mutual in-service training, exchange of information on clients, designating liaison personnel for the agencies, and developing a conflict resolution mechanism.

4. Centralization of the coordination and monitoring of agreement implementation through the establishment of an Agreement Implementation Committee, whose responsibilities include: recommending changes in statewide policy, as necessary, to eliminate barriers that impede joint service planning and delivery at the local and state level; insuring that initial local agreements are established and submitted within the designated time; and, in a timely manner, providing local agencies review of and comment on their local agreement. Additional responsibilities include: monitoring the effectiveness of local agreements, planning and overseeing of the staff development needed to disseminate and implement the cooperative agreement, and providing a forum for resolving service and policy issues arising out of the local agreement process.

5. Initiation and maintenance of interdependent service planning to develop innovative, alternative services and components within the public and private sector; to develop mutual agency goals; to develop a common data gathering and evaluation system related to the implementation of the cooperative agreement; to develop joint grant applications or other resources; and to initiate mutual staff development opportunities.

6. And the agreement specified the manner by which either party may initiate amendments to the cooperative agreement.

In accordance with the state-level agreement, both departments provided model formats to guide their local agencies in developing agreements between county mental health programs and area agencies on aging. The model provisions were similar in content and intent to the state-level agreement. Because the

deadline for submission of the local agreements was September 30, 1985, it is too early to assess their effectiveness in improving the delivery of services to the aged.

For further information on the state initiatives contact:

Kenneth Hook
Office of Mental Health
Room 303 Health & Welfare Building
Harrisburg, Pennsylvania 17120

Building Ties: A Mental Health and Aging Project
State of Michigan

The Building Ties Project (BTP) is a joint effort of the Michigan Office of Services to the Aging (OSA) and the Department of Mental Health (DMH) and is designed to improve mental health services for older adults through cooperation between local mental health and aging service providers. Developed by the Michigan Office of Services to the Aging in 1983, under a grant from the Administration on Aging (AoA), the Building Ties Project is an outgrowth of a 1978 state-administered AoA demonstration project (the Satellite Staff Project), which developed state level cooperation between OSA and DMH focusing on policy and program development for older adults with mental health needs.

The Building Ties Project is a statewide technical assistance package which works to foster a sense of shared responsibility and commitment among local human service agencies in addressing the unmet service needs of the aged population. Local interagency cooperation is facilitated through a program development workbook, training, and the use of process consultation techniques.

A maximum of 12 county-level agencies -- 6 community mental health agencies and 6 aging services providers -- participate each project year. Each participant agency designates a liaison to work with BTP staff and convenes a local interagency committee, which represents a crossection of provider organizations concerned with the delivery of mental health services to the aged. The committees assess local needs and propose a specific plan of action. Monthly meetings are held to consider three possible objectives: (a) the establishment of interagency programs and administrative linkages to improve coordination and cooperation in the delivery of services; (b) the review of local mental health and aging policies and the formulation of recommendations; and (c) the development of a joint proposal to expand existing mental health services.

The liaison persons receive training and ongoing consultation from project staff. Each member of the 12 interagency committees receives a program development workbook, which provides guidelines for needs assessments, problem identification, program planning, and the development of goals and proposed outcomes. At the request of the liaison, BTP staff attend the monthly committee meetings as resource persons, and provide specialized research, program and policy information. BTP staff do not become directly involved in the decision-making process, but work to facilitate committee action. Project staff maintain frequent phone contact with liaisons and conduct site visits to meet with liaisons in a consultative role to discuss program development concerns,

recommend specific consensus building strategies, clarify technical assistance materials, review committee action, and lend support and encouragement.

Two training sessions are held, with the first being held prior to project's implementation for orientation purposes and to present information on current mental health and aging issues, the consultation process, and factors influencing productive working relationships. The second training session is held at the project's halfway mark, to give liaisons information on advocacy, public awareness, and service delivery issues. A third meeting is held at the end of the project year to assess the impact of committee activities and to share future plans.

The BTP committees have achieved substantial success in developing plans and taking steps to improve mental health services for older adults in their respective communities. Benefits derived from project involvement include: (a) enhanced working relationships with other service agencies; (b) increased inter-organizational cooperation; (c) increased ability to establish systematic planning methods, resolve group process issues, and identify needed resources; and (d) reduced fragmentation and duplication of existing services. Some difficulties have also been identified, such as organizational resistance to change due to "turf issues," the unwillingness of some committee members to share work assignments, and time constraints imposed by the frequency of committee meetings.

The consultation approach employed by the Building Ties Project has been found to be an effective and cost efficient method for addressing the unmet mental health service needs of older adults at the local level. With only a modest committment of staff (1.5 full-time employees) and resources, participant communities stand to benefit from increased service programs, improved interorganizational relationships, and a wider public recognition of current service and policy questions.

For further information on the project contact:

Sally C. Grady, M.S.W.
Project Director
Michigan Office of Services to the Aging
P.O. Box 30026
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Systems Integration at the Program Level: Aging and Mental Health Spokane, Washington

A basic agreement was reached in 1978 between the Spokane Community Mental Health Center (CMHC) and the Eastern Washington Area Agency on Aging (EW/AAA) to target a network of interdependent in-home mental health and other services to elderly persons living in the community who were most at-risk of premature or unnecessary institutionalization. This agreement is based on the assumption that the mental health needs of the elderly -- especially the frail, vulnerable, or moderately to severely dysfunctional -- cannot be separated from their physical, social, and economic needs.

The elderly services program is composed of two highly integrated components: Telephone Information and Referral, and Multi-Disciplinary In-Home

Case Management. Each component receives approximately 60% of its funding from EW/AAA. The remaining funds come from the Washington State Mental Health Grant-in-Aid program and the National Institute on Drug Abuse. EW/AAA receives almost all of its funding from the Older Americans Act and the Washington State Senior Citizens Services Act.

The Telephone Information and Referral component, staffed by two telephone screeners, provides information and referral services for higher functioning older adults, and serves those who are experiencing little or mild dysfunction, or persons who have support systems willing and able to act on their behalf because they are experiencing mild psychiatric and/or cognitive impairment. Twenty-four-hour service is provided, through arrangement with the CMHC crisis service, and access to the in-home case management component.

The Multi-Disciplinary In-Home Assessment/Case Management (MDIHA/CM) component is mandated to help the elderly maintain their independence, prevent premature and/or unnecessary institutionalizaton, and improve the quality of life of older adults. MDIHA/CM is organized into five multidisciplinary teams, and staffed by fifteen case-managers, 5 team leaders (4 of whom are nurses), 1 half-time psychiatrist, and by resident physicians and a program coordinator. The interrelated elements of the case management approach include identification and location of the target population (gatekeepers), crisis intervention, assessment and evaluation, service and treatment planning, family work, supportive therapy, coordination of services (networking), advocacy, and continuity of care. The heart of the program is the in-home multidisciplinary approach. Staff psychiatrists and physicians from family medicine make home visits with case managers for the purpose of evaluation, diagnosis, and treatment.

The MDIHA/CM component employs a unique referral system called "gatekeepers" to help identify those high-risk elderly living in the community. Corporations, businesses, and other organizations that have contact with the most isolated elderly in the community, participate in the nontraditional referral program to help identify and locate high-risk elderly who would not self-refer and do not have relatives or others to act on their behalf.

The gatekeeper system -- which includes meter readers, credit office workers, and repair personnel from the electrical and natural gas utility companies, postal carriers, fuel oil dealers, policy and sheriff departments, grocery stores, pharmacies, and ambulance companies -- accounts for one out of three (37%) admissions to the MDICHM component. This can be compared to a self referral rate of 4% and a referral rate from friends and relatives of 22%. It has been found that ongoing training, communication after referral, and the ability to work effectively with those who are referred to be essential to the system's maintenance.

Once an at-risk elder has been admitted to the MDIHA/CM component, a comprehensive in-home assessment of the person's functioning is conducted. Staff members work to establish positive relationships with the elderly and to overcome the initial resistance, fear, suspiciousness, and hostility that is often present. Based on the assessment, a detailed service/treatment plan -- including medical, psychiatric, socioeconomic, environmental modification and medications -- is developed for each client, utilizing family and other support systems. Through the relationship with EW/AAA, preventive, supportive, and rehabilitative in-home services can be delivered, such as chore-homemaker

services, visiting nurses, day health care, home-delivered meals, and respite care.

Fourteen written coordination and referral agreements with other agencies, most of which are funded by the Eastern Washington Area Agency on Aging, have been negotiated. These agreements detail each agency's role, referral mechanisms, methods of resolving problems, and the sharing of training and other resources. Improved contact between agencies has been encouraged and all agencies involved in the cases presented at weekly case staffings, held by Elderly Services, are asked to attend those meetings. Elderly Services also provides twenty hours of in-service training to geriatric service staff, such as chore workers, on such topics as dementia, depression, mental status, and drug effects.

Currently, 22% of the Spokane CMHC's active clients are over age 60, compared to a national average of between 4% to 6%. Elderly Services believes, for instance, that it has contributed to the significant decline in the elderly suicide rate for Spokane County. Upon its implementation in 1978, 33% of the county's suicides were committed by those 60 years of age or older, and in 1983 this was lowered to 19%. Elderly Services credits their multidisciplinary approach, in which staff psychiatrists and family medicine physicians make home visits with social worker case managers, for their ability to maintain many elderly individuals in their own homes.

For further information on this program contact:

Ray Raschko, M.S.W.
Coordinator, Elderly Services
Spokane Community Mental Health Center
South 109 Division
Spokane, Washington 99202

Senior Outreach Services
Ventura County, California

In response to the underutilization of their services by the elderly, the Ventura County Mental Health Department has developed a mobile geriatric outreach team to offer specialized geriatric services. The goals of the outreach team are to make mental health services more accessible to the aged, to prevent inappropriate institutionalization, and maintain maximum independence of the older client. In pursuit of these goals the outreach services program utilizes consultation, education, public information, community organization, and a program of direct services.

The program's initial concerns were to overcome the problems of the older person's lack of knowledge about the availability of mental health services in the county, the reluctance of the aged to utilize services, and the lack of interaction between the mental health and aging services agencies. Some of the program's activities included a two-year series of "Creative Aging" workshops that were held across the county on mental health topics of interest (i.e., "The Emotional Ups and Downs of Later Life") along with training programs in aging that were developed for mental health staff. Staff were trained by specialists in aging and a program director was recruited with a specialization in geropsychology.

An interdisciplinary mobile outreach team was developed that was particularly responsive to the special circumstances of older adults. The team is comprised of a clinical/community geropsychologist as program manager, a community-oriented psychologist as director of community services, a clinical social worker, two mental health nurses, and a half-time psychiatrist -- all with community mental health experience.

The services of the outreach team are organized into three components: first, assessments and referrals are offered to elderly in crisis on a community client-contact basis -- which permits one or two visits at no charge. The assessments and referrals are usually made through the use of home visits, by an interdisciplinary team that evaluates and refers the client to appropriate services within the local social service network. The team determines whether outpatient therapy is appropriate, explains charges, and arranges for the initiation of therapy. The second component of the program, brief therapy, usually focuses on depression, paranoia, and adjustment and anxiety disorders. The third component, involving services to the aging network, consists of consultation with various agencies, inservice training, community education, and assistance in program development.

The problem of accessibility of services to older persons because of disability or lack of transportation has been resolved by the use of home visits by the mobile outreach team. Virtually all initial visits, and more than one-half of ongoing therapy visits, take place in the home.

The existing sliding-scale fees system used by the Department for mental health services has been adequate for the outreach unit. Low income clients are not charged; others may pay from $24 to $100 per year for services. No client is turned away because of an inability to pay.

Psychosocial accessibility is enhanced by the mobile team's consultation and education activities. Each team member provides training and case and program consultation to aging network agencies in addition to developing referral sources. By means of community education programs, discussion groups at housing and meal sites, and personal contact, the staff have become visible in the aging community. Using the same staff for clinical and community education activities, with the consequent generation of referrals, has helped make the program cost-effective.

Since the program's implementation, the elderly use of Ventura County Mental Health Services rose to 6.4% of the total client population (up from 2% in 1977). Among the other accomplishments of the program are: an increase in referrals from senior service agencies, a dramatic increase in the percentage of Hispanic seniors being served (to nearly the proportion of Hispanics in the county's elderly population), and the development of self-help groups for caretakers of memory-impaired persons.

For further information on this program contact:

Bob Knight, Ph.D.
Senior Outreach Services
Ventura County Mental Health Department
625 Santa Clara Street
Ventura, California 93001

Greater Southeast Multi-Service Senior Center
Washington, D.C.

The Greater Southeast Community Center For the Aging is a not-for-profit corporation that provides nursing home care, medical day care, and a variety of programs and services to the elderly. The Center offers a continuum of services for the aged through its three divisions: the Health Care Institute (a 180-bed teaching nursing home), the Multi-Service Senior Center, and the Division of Research, Education and Training.

Located on the grounds of the 450-bed acute care Greater Southeast Community Hospital, the Multi-Service Senior Center (MSSC) serves the well elderly, medical day care patients, and the frail elderly by providing recreational, nutritional, educational, case assessment, case management, and transportation services. The center also provides counseling services for participants and their families. Most of MSSC's funding is provided by the District of Columbia Office on Aging.

MSSC is an example of an aging services agency that initially offered mental health services to its clients in cooperation with Area D Community Mental Health Center, but, as it extended its own mental health staff, MSCC became increasingly independent with respect to service delivery. Their counseling program, provided by an MSW-level social worker, is short-term crisis-oriented treatment. MSSC continues to work cooperatively with the Area D CMHC that is located on the grounds of St. Elizabeths Hospital -- a federally-supported psychiatric hospital facility located near MSSC -- on a conjointly operated Saturday Socialization Program (SSP). SSP is a transitional program to help older patients deinstitutionalized from St. Elizabeths Hospital return to the community. Funded under a three-year grant from St. Elizabeths Hospital and the Department of Health and Human Service's Community Support Program, SSP offers a program for 30 participants, many of whom have experienced long periods of hospitalization, using a variety of therapeutic and case management techniques to help them make a successful transition to community residential facilities.

For further information on the center contact:

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Administrator
Greater Southeast Community Center For the Aging
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Appendix A

SUMMARY OF 1983 SURVEY AND SITE VISITS

Survey and Site Visits

When the Action Committee began to focus on the 1981 White House Conference on Aging recommendations calling for increased community mental health center (CMHC) services to older persons and for the coordination of local service delivery by the mental health and aging services network, it became apparent that under the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant program, enacted as part of the 1981 Omnibus Budget and Reconciliation Act, there would be no mechanisms to measure the scope of specific CMHC services to older persons or the impact of the block grant program on such services. The ADMS block grant provided little direction to states on program priorities (such as specialized aging programs), allocation of funds, or accounting requirements. As federal reporting requirements had been discontinued, there were no national data available to assess changes to service provisions due to the block grants. It was, therefore, necessary to undertake an independent survey of CMHCs to collect current data on local programs.

The Community Mental Health Center Survey Project was undertaken to assess the impact of the block grant program on the delivery of mental health services to older persons. The project consisted of two phases: first, a mail/telephone survey of CMHCs, with special attention given to the delivery of services to the aged, and second, a series of in-depth interviews, visiting CMHCs and area agencies on aging (AAAs). In the first phase of the project the Action Committee, in conjunction with the National Council of Community Mental Health Centers, mailed a questionnaire to 649 CMHCs requesting information on the impact of the block grant, specialized aging programs, funding sources, the client population, services provided to older patients, and professional and support staff. A total of 233 responses, representing 36% of the CMHCs, were obtained from 41 states.

The following is a summary of the survey findings:

- 48% of the CMHCs surveyed reported adverse effects due to the ADMS block grant.
- The elderly remain an underserved group, receiving only 6% of CMHC services.
- There has been a decrease in the number of specialized aging programs delivered through CMHCs.
- There has been a significant decrease in federal support for mental health care. Local and private support has been employed to restore a portion of the loss in funding.
- Clinical service staff have been adversely affected.
- The adverse effects of the block grant program are being felt nationwide.

The second phase of the project entailed site visit interviews with selected CMHCs and AAAs in 11 locations. The purpose of these interviews was to obtain more complete information about the impact of the block grant on CMHC programs and age-related services, and on the nature and extent of the interagency contact and cooperation between CMHCs and AAAs.

In the CMHC interviews, information was obtained about (a) the impact of the block grant on the overall operation of the centers and the composition of the client population; (b) the effects of the deinstitutionalization movement on overall client and older client populations; (c) the center's perceptions of the prevalence of mental impairment among the elderly; (d) the reasons for underutilization of mental health services by older persons; (e) the specialized aging programs and the specific services provided older clients, or why specialized programs were not provided; and (f) the frequency of interaction between CMHCs, the AAAs, and other community and state organizations delivering mental health and/or aging services.

The AAA interviews were more general in nature than those with CMHCs. Information was obtained on (a) the background of aging program services; (b) funding patterns and data on any mental health related services; (c) the nature of mental health problems experienced by local older clients and the impact of that clientele on existing programs; (d) the need for staff training in mental health and aging; and (e) the nature and extent of their interaction with CMHC and other mental health and/or aging programs providing direct services to mentally impaired elderly.

The following is a summary of the site visit findings:

- o CMHCs reported <u>adverse</u> effects on their activities related to block grant funding.
- o Block grants had a <u>negative</u> impact on geriatric services.
- o CMHCs reported <u>little contact</u> with area agencies on aging.
- o Aging programs <u>are</u> aware of the mental health service needs of their clients.
- o AAAs and CMHCs reported <u>almost no</u> coordinated service delivery and <u>little</u> routine interaction.
- o There is a need for cooperation between mental health and aging services networks.
- o There is need for in-service mental health training for aging service staff.

<u>Recommendations</u>

The most significant findings of the survey and site visits were (a) the adverse impact of the block grant program on CMHCs; (b) the aged remain an underserved population with CMHCs; (c) racial and ethnic minority elderly are severely underserved; (d) there have been decreases in specialized aging programs; and (e) there is little interagency cooperation between the mental health and aging services networks. In response to these findings and the

mental health recommendations of the 1981 White House Conference on Aging, the Action Committee developed the following recommendations for federal, state, and local reforms:

Recommended Federal Reforms

- o Abolish the block grant system of service funding.
- o Reinstate a categorical system of mental health service funding.
- o Expand Medicare mental health benefits to a level which parallels medical benefits coverage.
- o Amend the Older Americans Act to assure a coordinated approach between area agencies on aging and community mental health centers in meeting the mental health and psychosocial needs of the elderly.
- o The federal government should take administrative action to assure that the interagency agreement previously developed between the National Institute of Mental Health and the Administration on Aging mandating mental health and aging service systems cooperation in the development and provision of psychosocial services to the elderly be implemented in an expeditious manner.
- o Implement the Older Americans Act requirement that Title IV grants for mental health demonstration programs for older adults require the incorporation of the full range of mental health service needs of the aged.

Recommended State Reforms

- o State agencies on aging and state departments of mental health should take administrative action to assure coordination and cooperation in their planning, development, resource allocation, and service delivery, in order to provide and support an adequate continuum of psychosocial services to meet the diverse needs of older adults.
- o State governments should enact legislation to establish specifically targeted programs addressing the mental health needs of the elderly in all state mental health systems.
- o The directors of state agencies on aging, state departments of mental health, and directors of local area agencies aging and community mental health centers should assume an advocacy role on behalf of comprehensive mental health services for older adults before state legislatures, the Administration, and the Congress.
- o Full mental health coverage should be restored and maintained under Medicaid at the 1981 level (with allowances for inflation).
- o State agencies on aging and state departments of mental health should initiate in-service training programs in mental health and aging at both the state and local levels for mental health and aging service personnel.

Recommended Local Reforms

- o Local area agencies on aging and community mental health centers, and other mental health and aging service providers, should initiate formal inter-system coordination and interaction for the assessment, planning, development, and delivery of comprehensive mental health services to the aged.

- o Community mental health centers, and other public and privately funded mental health programs, should insure that adequate and suitable services are being delivered and allocated on an equitable basis to the aged in the community and particularly to the minority elderly.

- o Local aging networks and the mental health system should initiate joint training sessions for mental health and aging service providers at the community level.

- o Joint case management systems, involving both the aging and mental health networks, should be developed at the community level.

- o Interagency community action networks should be established at the local level to develop cooperative planning and program development for a continuum of mental health services for the aged.

As the purpose of the research project was to assess the impact of the block grants on the delivery of mental health services to the elderly in this country, the report focused primarily on deficiencies in the mental health system and current mental health policies. Nevertheless, the Action Committee would also like to formally recognize and commend the substantial contributions that Community Mental Health Centers and Area Agencies on Aging have made to the health and well-being of our nation's elderly through the dedication and hard work of their professional and support staff.

The full report was published in two volumes. Volume I presented the introduction and background to the survey, the results of the survey of community mental health centers, brief summaries of the site visits to community mental health centers and area agencies on aging, and recommendations for federal, state and local reforms. Volume II presented excerpts from the reports on site visits to community mental health centers and area agencies on aging, the survey questionnaire, guidelines for site visit interviews, and the levels of statistical significance for the data comparisons.

Appendix B

COMMUNITY MENTAL HEALTH CENTER QUESTIONNAIRE

General Instructions

The National Council of Community Mental Health Centers and the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging are co-sponsoring this survey to determine the effects of the Alcohol, Drug Abuse and Mental Health Services block grant on Community Mental Health Center services to the aged. The results from this survey will be used to aid in the advocacy effort for increased support for Community Mental Health Center programs and activities and for improved services for older persons. We, therefore, ask your assistance in providing the information requested.

Thank you for your prompt attention and reply. Please complete and return the questionnaire by May 31, 1985. Your responses will be kept strictly confidential. A stamped return envelope is enclosed for your use.

I. Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant: General Information on the Impact on Your Center

How has your Community Mental Health Center been affected by the federal ADMS block grant program? (Circle one closest to your best estimate)

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
Negative Impact					No Effect				Positive Impact	

In what ways has the block grant affected your Center? (Please check all that apply.)

	Increased	No Change	Decreased
Number of client visits	____	____	____
Client waiting list	____	____	____
Number of clinical staff	____	____	____
Staff turnover	____	____	____
Qualifications of newly hired clinical staff	____	____	____
Effort made to attract minority clients for service	____	____	____
Number of inservice training programs	____	____	____
Frequency of outreach services	____	____	____
Frequency of home visits	____	____	____
Frequency of consultation and education activities	____	____	____
Frequency of evaluation activities	____	____	____

Given an equal amount of funding, which method of federal funding would you prefer for your Center? (Please check only one.)

____ The current Block Grant system of funding.
____ The Categorical Method (used prior to the block grant).

Why? _____

II. FUNDING PATTERNS

As there was no uniform starting date for the block grant program, please provide information based on your Center's records for the 1981 fiscal year (the period prior to the block grant) and the 1984 fiscal year (the recently completed budget year). We understand that your state and federal funding sources may operate on different fiscal year dates, however, please endeavor to provide your best estimate.

Identify funding sources for the entire agency under each category and show totals from each source. (Round off to the nearest thousand and make your best estimate if precise dollar amounts are unavailable.)

	1981 Fiscal Year	1984 Fiscal Year
Federal & State Funding Sources:		
Alcohol, Drug Abuse and Mental Health Services block grant funds	$_____	$_____
Other block grant funds	$_____	$_____
Research/Demonstration grants	$_____	$_____
Medicare reimbursements	$_____	$_____
Older Americans Act funds	$_____	$_____
Medicaid	$_____	$_____
State mental health funds	$_____	$_____
State aging funds	$_____	$_____
Other: _____	$_____	$_____
Local Government Funding Sources:		
_____	$_____	$_____
_____	$_____	$_____
Private Funding Sources:		
United Way	$_____	$_____
Philanthropy	$_____	$_____
Insurance reimbursement (excluding Medicare/Medicaid)	$_____	$_____
Client fees	$_____	$_____
Other Sources of Income:		
_____	$_____	$_____
_____	$_____	$_____
Grand Total:	$_____	$_____

What was the total amount of Center funds devoted to services to the aged? _____ 1981 _____ 1984

III. AGING PROGRAM INFORMATION

Many programs define "aged" as age 65 and older. What is the definition of "aged" used by your Center?

_____ age 55 and over
_____ age 60 and over
_____ age 65 and over
_____ age 70 and over
_____ other (please specify: _____)

Does your Center currently have a specific program for the aged?

_____Yes
_____No, but there are plans to develop a program within the next five years.
_____No, and there are no plans to develop one within the next five years.

Did you have an aging program prior to the block grant (1981)?

_____No
_____Yes, from 19____ to 19____. Why was it discontinued? _____

Which of the following services does your Center currently provide to the aged? (Please check all those provided.)

_____Assessment
_____Screenings
_____Crisis Intervention
_____Emergency Services
_____Inpatient Services
_____Outpatient Services
_____Support groups/socialization groups
_____Services to families of aged clients
_____Psychopharmocological Clinic
_____Case Management
_____Information and Referral
_____Outreach Services
_____Day Care
_____Respite Care
_____Hospice Services
_____Forensic Services
_____Transportation
_____Please describe any services not listed: _____

What was the percentage of your Center's services to the aged?	1981	1984
Treatment services	____%	____%
Prevention and C & E services	____%	____%
Specialized services (outreach, home care)	____%	____%

Are any of the Center's staff specifically trained in the provision of mental health services to the elderly (as opposed to a general clinical background)?

_____Yes (If yes, how many staff are trained? _____)
_____No

Are there Center efforts that can be identified that are targeted to meet the needs of the racial/ethnic/ linguistic minority aged in your community?

_____No
_____Yes, please describe: _____

IV. INTERACTION WITH AREA AGENCIES ON AGING* AND OTHER ORGANIZATIONS
*(In some localities AAAs may be known as Council of Governments)

Does your Center have an ongoing relationship with an Area Agency on Aging (AAA)?

_____Yes, since _____, 19___
_____No (month)

Which of the following apply to your Center's relationship with the AAA? (Please check all that apply.)

_____Formal agreement or contract
_____Participation on joint planning and needs assessment
_____Funding from and/or with the AAA to provide services
_____Cooperation in joint staff training
_____Co-sponsorship of workshops and/or conferences
_____AAA is represented on CMHC board or advisory group
_____CMHC is represented on AAA board or advisory group
_____Sharing of facilities
_____Attendance at occasional events or meetings sponsored by AAA
_____Dissemination of information on mental health and services through AAA
_____Referrals
_____Staff liaison
_____Please describe any additional areas of cooperation: _____
_____
_____
_____

Please check all of the service delivery sites at which one or more of your Center's services are delivered:

_____ CMHC facility
_____ Area Agency on Aging
_____ Adult day care center
_____ Community Action Program
_____ Community residential facility
_____ State mental hospital
_____ Nursing home
_____ Hospice program
_____ Senior center or service site
_____ Church, club or other meeting place
_____ Client's home
_____ Prison
_____ Shelter for the homeless
_____ Other: _____
_____

Please describe any activities that have helped to foster community understanding and support for your Center.

_____
_____
_____
_____

V. CLIENT PROFILES

	1981 Fiscal Year	1984 Fiscal Year
Age and Sex of All Clients Served		
NUMBER of clients receiving mental health services:		
Age 1 - 17	_____	_____
Age 18 - 64	_____	_____
Age 65 - over	_____	_____
Total client VISITS	_____	_____
Visits by persons age 65 and over	_____	_____

What percentage of clients who are age 65 and over are:
Women? _____
Minorities? _____ Please check minority clients served:
___Black ___White ___Hispanic ___Asian/Pacific Islander
___American Indian/Alaska Native

VI. STAFFING PATTERNS

Number of professional staff:

Full time (35 hrs/week or more) _____
Part time (fewer than 35 hrs/wk) _____
Total full time equivalent staff _____

What percentage of the total professional staff are:

Women? _____
Minorities? _____ Please check minority professional staff:
___Black ___White ___Hispanic ___Asian/Pacific Islander
___American Indian/Alaska Native

Number of full-time equivalent staff:

Administrative staff _____
Paraprofessionals _____
Volunteer staff _____
Support/clerical staff _____

COMMENTS: (Please comment further on any aspect of your Center's activities which you wish to note, or provide any additional information you feel might be helpful)

_____
_____
_____
_____
_____
_____

VII. Would you like to receive a copy of the survey results? _____Yes _____No

Would you be willing to participate in a followup interview at a later date? _____Yes _____No

If yes, please provide the following information:

Name: _____
Title: _____
Agency: _____
Street: _____
City, State, Zip: _____
Telephone/Area Code: _____ _____ _____

THANK YOU FOR YOUR TIME AND EFFORT IN ANSWERING OUR QUESTIONS

Please return the completed form in the enclosed stamped envelope or mail to: Larry Rickards, Action Committee, 1200 Seventeenth Street, N.W., Room 329, Washington, D.C. 20036.

Appendix C

SITE VISIT INTERVIEW WITH
COMMUNITY MENTAL HEALTH CENTER

_____ _____
Site visit locality Interviewer

_____ _____
Name & Position of Interviewee Date of Interview

I. INTRODUCTION

Recently, this Community Mental Health Center participated in a survey sponsored by the National Council of Community Mental Health Centers and the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging. In opening the interview note that the survey, which is a follow-up to a similar survey conducted in 1983, represents the only ongoing nationwide effort assessing the impact of the Alcohol, Drug Abuse and Mental Health Services block grant program on the provision of mental health services to older persons. The cooperation of this Center is vital to the success of this project, which may provide a basis for increased federal funding of CMHCs. Thank the person for completing the questionnaire and for agreeing to the interview.

II. IMPACT ON GENERAL PROGRAM

A. In general, how has the implementation of the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant program affected this Center?

_____N/A _____Negatively _____No Effect _____Positively

Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

B. Since the ADMS block grant program was initiated (in 1981) has the composition of this Center's client population increased, stayed the same, or decreased with regard to the number of:

	Increased	No Change	Decreased
Aged clients	_____	_____	_____
Child/adolescent clients	_____	_____	_____
Female clients	_____	_____	_____
Male clients	_____	_____	_____
Racial/Ethnic minority clients	_____	_____	_____
Unemployed clients	_____	_____	_____
Alcohol/substance abuse clients	_____	_____	_____
Homeless	_____	_____	_____
Abused elderly clients	_____	_____	_____
Deinstitutionalized clients	_____	_____	_____
Rural clients	_____	_____	_____
Urban clients	_____	_____	_____
Refugee clients	_____	_____	_____
Other (Please explain)_____	_____	_____	_____

Comments: _____

_____

_____

_____

_____

D. Does your Center prefer the current Block Grant system of funding to the Categorical system used prior to the block grant? _____No _____Yes

Comments: _____

_____

_____

_____

_____

III. IMPACT ON AGING PROGRAM

A. What is the definition of "aged" used by this Center?

_____ Age 55 and over
_____ Age 60 and over
_____ Age 65 and over
_____ Age 70 and over
_____ Other (please specify: _____)

B. What percentage of this Center's clients are "aged"? _____%

C. Has the ADMS block grant program had any impact on the provision of mental health services to older people at this Center?
_____No _____Yes, in what way?
Comments: _____

_____

_____

_____

_____

D. Has the decrease in federal funding for mental health services resulted in the development or exacerbation of any problems related specifically to the delivery of services to the aged at this Center? Please respond regarding:

	N/A	Increase	No Change	Decrease
Number of older client visits	____	____	____	____
Client waiting list	____	____	____	____
Client fees	____	____	____	____
Eligibility criteria	____	____	____	____
Number of clinical staff	____	____	____	____
Staff turnover	____	____	____	____
Qualifications of newly hired staff	____	____	____	____
Efforts made to attract minority clients for service	____	____	____	____
Number of in-service training programs	____	____	____	____
Frequency of outreach services	____	____	____	____
Frequency of home visits	____	____	____	____
Frequency of nursing home visits	____	____	____	____
Frequency of consultation and education activities	____	____	____	____
Frequency of evaluation activities	____	____	____	____
Frequency of needs assessment projects	____	____	____	____
Amount of prevention activity	____	____	____	____
Amount of public information activity	____	____	____	____
Increased competition with other agencies for clients	____	____	____	____
Amount of administrative paperwork	____	____	____	____

Comments: _____

_____

_____

E. Has this Center conducted an assessment within the past two years to determine the need for mental health services among the elderly in its catchment area?

_____No
_____Yes.

What is the prevalence of mental impairment among the elderly in the community. Please rank by dominant category: Begin with 1, as the most common, and rank the prevalence of:

_____Alcohol abuse
_____Substance abuse
_____Medication interaction disorders
_____Elder abuse
_____Family/marital problems
_____Social maladjustment
_____Anxiety disorders
_____Depressive disorders
_____Mental retardation
_____Adjustment disorders
_____Schizophrenic disorders
_____Paranoid disorders
_____Organic brain syndromes
_____Dementia
_____Other (please explain): _____

_____

_____

_____

_____

F. What do you perceive to be the major factors that impede the delivery of mental health services to the elderly in this Center? (check all that apply)

_____Decreased funding for aging services
_____Lack of service utilization by the aged
_____High demand for services by other age groups
_____Staff reluctant to work with the aged
_____Staff not trained to work with the aged
_____Staff reductions
_____Language and cultural barriers between staff and clients
_____Stigma attached to "mental illness" by the aged
_____Lack of transportation to services
_____Lack of home-delivered services
_____Client waiting period to receive services
_____Reliance on family and friends for support
_____Other: _____

_____

Comments: _____

_____

_____

_____

_____

G. a) Are any of the Center's staff specifically trained in the provision of mental health services to the elderly (as opposed to a general clinical background)?

_____No
_____Yes (If yes, how many staff are trained? _____)

b) If yes, has the number of trained staff changed with the initiation of the block grant program?

_____Increased _____No Change _____Decreased

c) Since the initiation of the block grant program, has there been any change in the services provided by these staff ?

_____No
_____Yes (If yes, please specify what changes _____

_____

_____

_____

_____

_____

Comments: _____

_____

_____

_____

_____

H. NOTE. Based on the Center's survey response, the interviewer will know if the CMHC has an aging program.

Use Version 1, if there is currently an aging program;
Use Version 2, if there was once an aging program but it has been discontinued; and
Use Version 3, if the Center never had an aging program.

Version 1. From the questionnaire received, this Center has indicated that it has an aging program.

a) What services are provided as part of the aging program? (Please check all that apply):

_____ Inpatient services
_____ Outpatient services
_____ Partial hospitalization
_____ Crisis intervention/emergency services
_____ Prevention services
_____ Consultation services
_____ Outreach services
_____ Home care
_____ Service to nursing home patients
_____ Case management
_____ Other (explain): _____

Comments: _____

_____

_____

_____

_____

_____

Version 2. This Center indicated that it had an aging program at one time.

a) Why was the program discontinued? (Check all that apply):

_____ Decreased funding
_____ Decreased referrals
_____ Increased demand from other age groups
_____ Lack of community support
_____ Lack of utilization by the aged
_____ Priorities shifted to more severely disturbed clients
_____ Staff attitudes towards the aged
_____ Staff not trained to work with the aged
_____ Staff decreases
_____ Other (please explain): _____

_____

_____

_____

_____

b) Does this Center plan to reinstitute an aging program within the next year? _____No _____Yes. Comments:_____

_____

_____

_____

_____

_____

c) What are the factors which may help to reactivate the aging progam? (check all that apply)

_____ Increased staff
_____ Increased referrals
_____ Increased funding for Center
_____ Increased community support
_____ Demand for aging services
_____ Staff willingness to work with the aged
_____ Staff trained to work with the aged
_____ Other (explain): _____

Comments: _____

_____

_____

_____

_____

Version 3. This Center indicated that it has never had an aging program.

a) What are the reasons that an aging program has not been developed? (Check all that apply):

_____ Staff attitudes toward the elderly
_____ Staff not trained to work with the elderly
_____ Insufficient resources
_____ Few elderly with mental health problems
_____ Reluctance of the elderly to seek mental health services
_____ High demand for services from younger age groups
_____ Other: _____

_____

_____

b) Did this Center at any time plan to develop an aging program?
_____No
_____Yes, why were the plans not implemented? _____

_____

_____

_____

_____

_____

_____

c) Does this Center plan to develop an aging program within the next five years? _____No _____Yes (If yes, when will implementation take place _____

_____

Comments: _____

_____

_____

_____

_____

IV. INTERACTION WITH OTHER AGENCIES

A. Community Mental Health Centers may have ongoing relationships and interactions with other community organizations that provide services to the elderly. We are interested in obtaining information on aging services only. "No Contact" - use a check (✓) if the CMHC has no contact with that organization; otherwise, leave blank. "Contact Frequency" - use the following abbreviations: D = daily contact, W = weekly contact, M = monthy contact, I = infrequent contact. "Liaison Staff" - write in "Yes" if the CMHC has a designated liaison contact person to the other agency; "No" if they do not. "Initiates Contact" - use the following abbreviations: C = CMHC initiated contact; O = other organization initiates contact.

	No Contact	Contact Frequency	Liaison Staff	Initiates Contact
Area Agency on Aging (No. worked with:_____)				
Adult day care center				
Multi-purpose Senior Center/ nutrition center				
Community Action Program				
Community residential facility				
Skilled nursing facility				
Intermediate care facility				
Board & care homes				
Hospice program				
Shelter for the homeless				
Interfaith agencies				
Private physicians				
Private psychiatric hospital				
State/County mental hospital				
Department of Public Health				
Protective services unit				
Law enforcement agency				
Judicial/court system				
Prison/jail				
Social welfare office				
Social Security Administration				
Other: _____				
_____				

Comments: _____

_____

_____

_____

B. What is usually the nature of the Center's interaction with other agencies regarding older clients? (check all that apply)

_____ Assessment/screening
_____ Direct service to clients
_____ Referral
_____ Case management
_____ Clinical consultation
_____ Advocacy
_____ Discharge planning
_____ Administrative
_____ Other, explain: _____

_____

_____

_____

_____

C. How has the implementation of the block grants affected this Center's interacaction with other agencies?

_____N/A _____Increased _____No Change _____Decreased

Comments: _____

_____

_____

_____

_____

D. How are older clients referred to this Center? (please rank: 1 = most frequent referral source)

_____Discovered through Center's outreach efforts
_____Area Agency on Aging referral
_____Physician referral
_____Family referral
_____Self-referral
_____Forced referral (police/court system)
_____Referral from other agencies - specify which agencies: _____

_____

_____

_____

_____

E. Are there other community agencies within this Center's catchment area providing mental health services to the elderly? _____No _____Yes.
Which: _____

_____

_____

_____

_____

_____

V. FUTURE DIRECTIONS

A. Block grants are part of an initiative to shift responsibility for social programs to state and local government and the private sector. In your opinion, for this community which nonfederal funding sources have been responsive to the need for mental health programs serving older persons (please rank: 1 = most responsive).

_____State Government
_____County Government
_____Local Government
_____Private Corporations
_____Private Foundations
_____Community Fund Drive
_____Other (explain): _____

_____

_____

_____

B. Do you believe these sources would respond to your needs if the Federal government totally withdraws financial support? _____No _____Yes.
Comments: _____

_____

_____

_____

_____

_____

C. Should the CMHC be the primary agency for the delivery of mental health services to older persons? _____No _____Yes.
Comments:_____

_____

_____

_____

_____

_____

_____

VI. ADDITIONAL COMMENTS

Please add any comments about the Center that you would like to make, such as: exemplary programs for delivery services to the elderly, creative financing, citizen involvement in the activities of the Center, examples of good local/state government planning, etc. Please also comment on interesting issues of local concern, topics that emerged in the visit that don't fit our standardized questions, and anecdotal impressions about the Center.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Appendix D

SITE VISIT INTERVIEW WITH
AGING ORGANIZATION

Site visit locality _____ Interviewer _____

Name & Position of Interviewee _____ Date of Interview _____

Mental Health Background of Interviewee _____

I. INTRODUCTION

Recently, the National Council of Community Mental Health Centers and the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging conducted a survey of Community Mental Health Centers. In opening the interview, note that the survey, which is a follow-up to a similar survey conducted in 1983, represents the only ongoing nationwide effort assessing the impact of the Alcohol, Drug Abuse and Mental Health Services block grant program on the provision of mental health services to older persons. Since the Aging Organization is likely to deal with a broader segment of the older population than that seen by the CMHC, the Agency is in a unique position to comment on the delivery of mental health services to older persons. They may also soon be in a position to deliver mental health-related services to the elderly due the the new mental health provision in the Older Americans Act. Thank the person for agreeing to the interview.

II. GENERAL INFORMATION

A. What are the services offered by, funded by, or contracted for by this Agency? Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

III. MENTAL HEALTH INFORMATION

A. Does this Agency have any mental health professionals (psychiatric nurse, psychiatrist, psychologist, social worker) on its Board of Directors? _____No _____Yes On staff? _____No _____Yes
Comments: _____

_____

_____

_____

B. Are any of the services provided by the Agency mental health-related?
_____ No
_____ Yes, please check the services offered:

_____ Telephone reassurance
_____ Crisis intervention
_____ Widowhood counseling
_____ Support groups
_____ Psychotherapy
_____ Other: _____
Comments: _____

_____

_____

_____

_____

C. Does this Agency have plans to implement the new provisions of the Older Americans Act to provide "services to support the mentally impaired elderly in the community"?
_____ No
_____ Yes: _____Partial Implementation _____Full Implementation
What is the timing for implementation?_____

Comments: _____

_____

_____

_____

D. Does the Agency provide training concerning mental health and aging?

_____ No
_____ Yes (check all that apply):

_____ In-service training of own staff
_____ Training to contractors
_____ Training to health professionals
_____ Training of home-care staff
_____ Public information programs
_____ Written materials (pamphlets, monographs)
_____ Other: _____

Comments: _____

_____

_____

_____

E. Has this Agency conducted or contracted for an assessment of the need for mental health services among the elderly in the community within the last two years?

_____ No
_____ Yes

Comments: _____

_____

_____

_____

F. What is your perception of the prevalence of mental impairment among the elderly in the community? (please rank by dominant category the top five (5) disorders: 1 = most prevalent):

_____ Alcohol abuse
_____ Substance abuse
_____ Medication interaction disorders
_____ Elder abuse
_____ Family/marital problems
_____ Social maladjustment
_____ Anxiety disorders
_____ Depressive disorders
_____ Mental retardation
_____ Adjustment disorders
_____ Schizophrenic disorders
_____ Paranoid disorders
_____ Organic brain syndrome
_____ Dementia
_____ Other (please explain): _____

Comments: _____

_____

_____

_____

_____

_____

G. How would you characterize the Agency clients with mental health problems? (please rank by dominant category: 1 = most prevalent):

_____ Deinstitutionalized mental hospital patients
_____ Street people/homeless
_____ Persons with chronic health problems
_____ Boarding home residents
_____ Nursing home residents
_____ Widows/widowers
_____ Refugees
_____ Other: _____
Comments: _____

_____

_____

_____

_____

H. Does the presence of mentally impaired clients present any problems to the Agency's ongoing aging programs?
_____ Not Applicable
_____ No
_____ Yes, what do you think could be done to overcome the problem posed by mentally impaired clients? Comments:_____

_____

_____

_____

_____

_____

I. Which of the following do you perceive to be the major factors that impede the delivery of mental health services to the elderly? (Check all that apply):

_____ Lack of available mental health services
_____ Lack of transportation to services
_____ Lack of funding for mental health services for the aged
_____ Client waiting period to receive services
_____ Negative attitudes of mental health staff towards the aged.
_____ Reluctance of the aged to request mental health services
_____ Lack of mental health outreach programs
_____ Lack of home-delivered services
_____ Social stigma attached to "mental illness"
_____ Other: _____
_____ _____

Comments: _____

_____

_____

_____

IV. INTERACTION WITH OTHER AGENCIES

A. Does this Agency have an ongoing relationship with a Community Mental Health Center (CMHC)?

_____ No
_____ Yes, since _____, 19 _____. How many CMHCs? _____

Which of the following apply to the Agency's relationship with the CMHC (Check all that apply):

_____ Formal agreement or contract
_____ Participation on joint planning and needs assessment
_____ Funding from and/or with the CMHC to provide services
_____ Cooperation in joint staff training
_____ Co-sponsorship of workshops and/or conferences
_____ CMHC is represented on the Agency's board or advisory group
_____ Agency is represented on the CMHC board or advisory group
_____ Sharing of facilities
_____ Attendance at occasional events or meetings sponsored by CMHC
_____ Dissemination of information on mental health and services offered at the CMHC
_____ Referrals to the CMHC
_____ Staff liaison
_____ Please describe any additional areas of cooperation: _____

_____

_____

B. Aging Organizations may have ongoing relationships and interactions with other community organizations that provide services to the elderly. "No Contact" - use a check (✓) if the Agency has no contact with that organization; otherwise, leave blank. "Contact Frequency" - use the following abbreviations: D = daily contct, W = weekly contact, M = monthy contact, I = infrequent contact. "Liaison Staff" - write in "Yes" if the Agency has a designated liaison contact person to the other agency; "No" if they do not. "Initiates contact" - use the following abbreviations: A = Agency initiated contact; O = other organization initiated contact.

	No Contact	Contact Frequency	Liaison Staff	Initiates Contact
Community Mental Health Center				
State/County Mental Hospital				
State Office of Mental Health				
Senior Centers				
Other AAAs				
Nursing home/Long-term care Facility				
Board & Care Home				
Private Psychiatric Hospital				
Private Mental Health/ Counseling Clinic				
General Hospital/Outpatient Clinic				
Private Physician				
Department of Public Health				
Social Welfare Office				
Law Enforcement Agency				
Other:_____				
_____				

Comments: _____

_____

_____

_____

_____

_____

_____

_____

C. What is the usual the nature of the Agency's interaction with other agencies regarding older clients? (check all that apply):

_____ Referral
_____ Case Management
_____ Clinical Consultation
_____ Advocacy
_____ Administrative
_____ Discharge Planning
_____ Other: _____
Comments: _____

_____

_____

D. How has the implementation of the block grants affected this Agency's interaction with other agencies?
_____ N/A _____ Increased _____ No Change _____ Decreased
Comments: _____

_____

_____

_____

V. FUNDING INFORMATION

A. Has this Agency's funding changed with regards to:

	N/A	Increased	No Change	Decreased
Older Americans Act Grants	_____	_____	_____	_____
Social Service Block Grant	_____	_____	_____	_____
Community Services Block Grant	_____	_____	_____	_____
Other Federal sources:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
State sources:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Private sources:				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Service Fees	_____	_____	_____	_____
Contributions	_____	_____	_____	_____

Comments: _____

_____

B. What has been the impact of funding changes on the Agency?

	N/A	Increased	No Change	Decreased
Number of Service Staff	____	____	____	____
Staff Turnover	____	____	____	____
Number of Contracts for Services	____	____	____	____
Types of Services Contracted for	____	____	____	____
Efforts Made to Attract Minority Contractors	____	____	____	____
Number of In-Service Programs	____	____	____	____
Frequency of Evaluation Activities	____	____	____	____
Amount of Administrative Paperwork	____	____	____	____
Other: _____	____	____	____	____
_____	____	____	____	____

Comments: _____

_____

_____

_____

_____

C. Block grants are part of an initiative to shift responsibility for social programs to state and local governments and to the private sector. In your opinion, for this community which nonfederal funding sources have been responsive to the need for mental health programs serving older persons? (please rank: 1 = most responsive):

_____ State Government
_____ County Government
_____ Local Government
_____ Private Corporations
_____ Private Foundations
_____ Community Fund Drive
_____ Other: _____
_____ _____

Comments: _____

_____

_____

_____

D. Do you believe these sources would respond to the need for mental health programs serving older persons if the Federal government totally withdrew financial support?

_____ No
_____ Yes
Comments: _____

_____

_____

_____

_____

VI. OTHER

A. What organizations in your community are the most appropriate to provide mental health services to older people? (please rank: 1 = most appropriate).

_____ Community Mental Health Center
_____ State/County Mental Hospital
_____ Area Agencies on Aging
_____ Senior Centers
_____ Private Psychiatric Hospitals
_____ Private Mental Health/Couseling Center
_____ General Hospital/Outpatient Clinic
_____ Private Psychologists/Psychiatrists/Social Workers
_____ Social Welfare Office
_____ Other: _____

Comments: _____

_____

_____

_____

_____

V. ADDITIONAL COMMENTS

Here you may want to add comments about the Agency, such as: exemplary programs for contacting elderly clients, creative financing, citizen involvement in activities, examples of good local/state government planning, etc. You may also want to comment on interesting issues of local concern, or topics that emerged in the visit that don't fit our standardized questions; anecdotal impressions about the Agency, etc.

Appendix E

LEVELS OF STATISTICAL SIGNIFICANCE

1. Page 15: X^2 (1, N = 174) = 1969.37, $p<.001$
2. Page 16: X^2 (2, N = 204) = 12.36, $p<.001$
3. Page 21: t (198) = 5.39, $p<.001$
4. Page 21: X^2 (1, N = 199) = 4.19, $p<.05$
5. Page 21: X^2 (1, N = 199) = 5.32, $p<.01$
6. Page 21: X^2 (1, N = 199) = 19.26, $p<.001$
7. Page 21: X^2 (1, N = 199) = 18.52, $p<.001$
8. Page 21: X^2 (1, N = 199) = 4.16, $p<.05$
9. Page 21: X^2 (1, N = 199) = 32.96, $p<.001$
10. Page 23: X^2 (9, N = 199) = 29.17, $p<.001$
11. Page 23: F (9, 142) = 2.07, $p<.05$
12. Page 23: F (9, 142) = 2.07, $p<.05$
13. Page 24: F (2, 140) = 5.11, $p<.01$
14. Page 24: X^2 (2, N = 150) = 44.80, $p<.001$
15. Page 24: X^2 (4, N = 149) = 40.22, $p<.001$
16. Page 24: X^2 (4, N = 149) = 111.22, $p<.001$
17. Page 24: X^2 (4, N = 149) = 58.13, $p<.001$
18. Page 24: X^2 (4, N = 150) = 95.58, $p<.001$
19. Page 24: X^2 (4, N = 149) = 89.52, $p<.001$
20. Page 24: X^2 (4, N = 150) = 101.40, $p<.001$

21. Page 24: X^2 (4, N = 147) = 60.60, $p<.001$

22. Page 24: X^2 (4, N = 148) = 35.29, $p<.001$

23. Page 24: X^2 (4, N = 149) = 47.62, $p<.001$

24. Page 24: X^2 (2, N = 172) = 5.32, $p<.05$

25. Page 24: E (2, 171) = 6.03, $p<.01$

26. Page 24: E (2, 88) = 4.43, $p<.01$